Electroconvulsive Therapy (ECT)

<table>
<thead>
<tr>
<th>BEACON HEALTH STRATEGIES, LLC</th>
<th>ORIGINAL EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAWAII LEVEL OF CARE CRITERIA</td>
<td>2013</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CURRENT EFFECTIVE DATE</td>
</tr>
<tr>
<td></td>
<td>Jun 23, 2017</td>
</tr>
</tbody>
</table>

I. Description

Electro-Convulsive (ECT) Therapy is a procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity while the member is under general anesthesia. This procedure can be administered in a variety of settings, ranging from a licensed hospital to outpatient settings. The decision to pursue ECT treatments is based on a risk/benefit analysis based on the member’s history, medical issues, symptomatology, and anticipated adverse side effects. Providers must complete a work-up including medical history, physical examination, and any indicated pre-anesthetic lab work to determine whether there are contraindications to ECT-related anesthesia and that there are no less intrusive alternatives before scheduling administration of ECT. The member must, as required by state or federal specific requirements, provide separate written informed consent to ECT on forms provided by the specific state mental health agency, as consent to other forms of psychiatric treatment are considered separate. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.

In general, an acute course of ECT will consist of 3 sessions per week for a total of 6 to 12 sessions. For members who achieve remission with ECT but are not able to maintain remission with pharmacotherapy, ECT may be administered as a maintenance treatment and is provided at a reduced frequency (e.g., weekly, biweekly, monthly). Maintenance ECT may be indicated for long-term maintenance when there is evidence that discontinuation or reduction in frequency is likely to result in a relapse.

II. Criteria/Guidelines

A. Admission Criteria

All of the following criteria 1-5 must be met:

1. DSM or corresponding ICD diagnosis of major depression, schizophrenia, schizoaffective mood disorder, or other disorder with features that include mania, psychosis, and/or catatonia;
2. Member has been medically cleared and there are no contraindications to ECT (i.e. Intracranial or cardiovascular, or pulmonary contraindications);
3. There is an immediate need for rapid, definitive response due to at least one of the following:
   a. Significant risk of harm to self or others;
   b. Catatonia
   c. Intractable manic episode
d. Other treatments could potentially harm the member due to slower onset of action.
4. The benefits of ECT outweigh the risks of other treatments as evidenced by at least one of the following:
   a. Member has not responded to adequate medication trials;
   b. Member has had a history of positive response to ECT.
5. Maintenance ECT, as indicated by all of the following:
   a. Without maintenance ECT member is at risk relapse
   b. Adjunct therapy to pharmacotherapy
   c. Sessions tapered to lowest frequency that maintains baseline

B. Continued Stay Criteria
All of the following criteria 1-8 must be met:
1. The member continues to meet admission criteria;
2. An alternative treatment would not be more appropriate to address the members ongoing symptoms;
3. The member is in agreement to continue treatment of ECT;
4. Treatment is still necessary to reduce symptoms and improve functioning;
5. There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress;
6. The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects;
7. There is documented coordination with family and community supports as clinically appropriate;
8. Medication assessment has been completed when appropriate and medication trials have been initiated or ruled out.

III. Limitations/Exclusions

A. Discharge Criteria
Any one or more of the following criteria:
1. Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive.
2. Member withdraws consent for treatment and does not meet criteria for involuntary mandated treatment.
3. Member does not appear to be participating in the treatment plan.
4. Member is not making progress toward goals, nor is there expectation of any progress.
5. Member’s individual treatment plan and goals have been met.
6. Member’s natural support (or other support) systems are in agreement with following through with member care, and the member is able to be in a less restrictive environment

B. Exclusions
Any of the following criteria are sufficient for exclusion from this level of care:
1. The individual can be safely maintained and effectively treated with a less intrusive therapy; or
2. Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific individual from this level of care. Such conditions include but are not limited to:
   a. unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease;
   b. aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure;
   c. increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions;
   d. recent cerebral infarction;
   e. pulmonary conditions such as severe chronic obstructive pulmonary disease, asthma, or pneumonia; and,
   f. anesthetic risk rated as American Society of Anesthesiologists level 4 or 5.

IV. Administrative Guidelines
A. Precertification is not required. HMSA and Beacon reserves the right to perform retrospective review using the above criteria to validate if service rendered met payment determination criteria.

B. Applicable codes:

<table>
<thead>
<tr>
<th>Revenue</th>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>901</td>
<td>90870</td>
<td>ECT Inpatient or Outpatient Therapy – single seizure</td>
</tr>
<tr>
<td>901</td>
<td>90871</td>
<td>ECT Inpatient or Outpatient Therapy – multiple seizures</td>
</tr>
</tbody>
</table>

V. Important Reminder
The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.
Beacon uses its LOC criteria as guidelines, not absolute standards, and considers them in conjunction with other indications of a member’s needs, strengths, and treatment history in determining the best placement for a member. Beacon’s LOC criteria are applied to determine appropriate care for all members. In general, members will only be certified if they meet the specific medical necessity criteria for a particular LOC. However, the individual’s needs and characteristics of the local service delivery system are taken into consideration.

In addition to meeting Level of Care Criteria; services must be included in the member’s benefit to be considered for coverage.

VI. References
1. MCG Health Behavioral Health Care 21st Edition Copyright © 2017 MCG Health, LLC

VII. Related Policies

A. CSNT 123.1 Minimum Program Standards by Level of Care
B. CUR 152 Application of Level of Care Criteria and Authorization Procedures - Commercial
C. CUR 153 Application of Level of Care Criteria and Authorization Procedures - Medicaid