| Section:<br>**Clinical Practices** | Policy Name:<br>**Electroconvulsive Therapy Authorization** | Policy Number:<br>**MHL 12.12** |
|---|---|---|
| Owner:<br>**Manager of UM & Call Center** | Reviewed By:<br>**Elizabeth Guisinger, LPC, CAADC**<br>**Bangalore Ramesh, MD** | Total Pages:<br>**4** |
| Required By:<br>☐ **BBA** ☐ **MDHHS** ☐ **NCQA**<br>☒ **Other (please specify):**<br>**See References** | Final Approval By:<br>Beth Guisinger (Dec 8, 2021 06:48 EST)<br>Bangalore K Ramesh (Dec 8, 2021 11:38 EST) | Date Approved:<br>Dec 8, 2021 |
| Application:<br>☒ **SWMBH Staff/Ops**<br>☐ **Participant CMHSPs**<br>☐ **SUD Providers**<br>☒ **MH/IDD Providers**<br>☐ **Other (please specify):**<br>__________ | Line of Business:<br>☐ **Medicaid**<br>☐ **Healthy Michigan**<br>☐ **SUD Block Grant**<br>☐ **SUD Medicaid**<br>☒ **MI Health Link**<br>☐ **Other (please specify):**<br>__________ | Effective Date:<br>**11/14/2016** |

**Policy:** No member of Southwest Michigan Behavioral Health (SWMBH) shall be the subject of Electroconvulsive Therapy (ECT) or any procedure intended to produce convulsions or coma unless determined to be fully informed and consenting to participation.

**Purpose:** To set forth guidelines regarding the authorization and use of ECT for members of SWMBH.

**Scope:** ECT requires prior authorization/coverage determination when directly funded through SWMBH, prior to delivery of service. This procedure intends to assure proper eligibility determination for ECT, by appropriate clinical staff. Authorization requests will be reviewed and determined by an appropriate SWMBH clinician, which will be dependent on the member's clinical presentation, treatment history and mitigating factors.

**Responsibilities:** Utilization Management (UM) staff are responsible for collecting necessary clinical documentation to present to board-certified psychiatrist for authorization determination for outpatient and inpatient ECT treatment. SWMBH Medical Director and/or other board-certified psychiatrist who will provide determinations on outpatient and/or inpatient ECT authorization requests.

**Definitions:** Electroconvulsive Therapy: a procedure in which electric currents are passed through the brain, intentionally triggering a brief seizure. ECT seems to cause changes in brain chemistry that can quickly reverse symptoms of certain mental illnesses. It often works when other treatments are unsuccessful.

**Standards and Guidelines:**

A. ECT or other procedures intended to produce convulsions or coma cannot be initiated unless consent is obtained from one of the following:
   1. The member, if he or she is over 18 years old and does not have a guardian for medical purposes, or
   2. The member's guardian who has legal authority to consent to medical care and procedures, or
   3. A representative authorized to consent to ECT under a durable Power of Attorney or other Advance Directive.

B. A member may receive ECT from a provider authorized and licensed to provide ECT. The following provisions must be complied with:
   1. Written signed consent will be entered into the individual's clinical record by the provider prior to the initiation of treatment.
   2. The consent will specify a number of ECT treatments within a stated time period.
   3. The provider must inform the individual, or other appointed legal representative as indicated above, that they may withdraw the consent at any time during the course of treatment.
   4. If the procedure is considered advisable for a member and an individual eligible to give consent is not located after diligent effort, upon court petition and after a hearing, probate court may consent to administration of the procedure in lieu of individual consent.

C. All of the following medical necessity criteria must be met for admission/initial authorization of ECT, and documented in the member's record:
   1. Member has a documented Diagnostic and Statistical Manual of Mental Disorders (DSM) or corresponding International Classification of Diseases (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, cardiovascular, or pulmonary contraindications)
   3. There is an immediate need for rapid, definitive response due to at least one of the following:
      a. Severe unstable medical illness;
      b. Significant risk to self or others;
      c. Catatonia
      d. Other somatic 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 (i.e. at least two courses of antidepressant medication at maximum does for an adequate length of time);
      b. Member and/or member's family member has/have 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 of relapse
      b. Adjunct therapy to pharmacotherapy
      c. Sessions tapered to lowest frequency that maintains baseline

D. All of the following medical necessity criteria must be met for continued authorization of ECT, and documented in the member's record:
   1. The member continues to meet admission criteria;
   2. An alternative treatment would not be more appropriate to address the member's 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 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.

Any authorization determination for Electroconvulsive Therapy that results in a denial, will be made by SWMBH's Medical Director, or another board-certified psychiatrist, who is licensed in the State of Michigan.

**References:**

A. Public Act 258, Michigan Mental Health Code MCL 330.1717
B. MDHHS AR 330.7017
C. MCG Medical Necessity Criteria, Electroconvulsive Therapy (ECT), B-802-T

**Attachments:**

A. 12.04A ECT Request
B. 12.04B Request for Additional ECT Treatments

**Revision History**

| Revision # | Revision Date | Revision Location | Revision Summary | Revisor |
|---|---|---|---|---|
| Initial | 4/26/2019 | Scope, Responsibilities, Procedure, Effectiveness Criteria<br><br>Procedure | No in previous version<br><br>All ECT requests will be presented to Medical Director or another board-certified psychiatrist to make determinations. | E. Guisinger |
| 1 | 6/8/2020 | Removed procedure and attachments from policy | Removed procedure and attachments from policy/Annual review | E. Guisinger |
| 2 | 10/29/2020 | References | MCG Medical Necessity | E. Guisinger |
| 3 | 11/29/2021 | Effective Date | Corrected effective date that was incorrectly modified when moved to new template | E. Guisinger |
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# MHL 12.12 Electroconvulsive Therapy Authorization

Final Audit Report 2021-12-08

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|---|---|
| Created: | 2021-12-07 |
| By: | Jody Vanden Hoek (jody.vandenhoek@swmbh.org) |
| Status: | Signed |
| Transaction ID: | CBJCHBCAABAAeoyerWHfs2z5bVIRgGPe7j4zCjrmNctU |

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# 12.04A SWMBH ECT Request Form

| Patient Name: | DOB: | SmartCare ID#: |
|---|---|---|
| Provider/Facility: | Provider/Facility Phone #: | |
| Anticipated Start Date: | Anticipated End Date: | |
| Requested Number of Sessions: | Frequency of Sessions: | |
| Level of Care for ECT: ☐ Inpatient ☐ Outpatient | Physician Name Requesting: | |
| Outpatient Psychiatrist Name: | | |

**Primary Diagnosis:**

☐ Major Depression ☐ Schizophrenia ☐ Schizoaffective Mood Disorder

Other Disorder with Features of mania, psychosis and/or catatonia: ______________

DSM-5 Dx:

**Has the member been medically cleared/no contraindications to ECT?** *(i.e. Intracranial, cardiovascular, or pulmonary contraindications)*

☐ Yes ☐ No

**There is an immediate need for rapid, definitive response due to:** ***(check at least one of the following)***

☐ Severe unstable medical illness ☐ Significant Risk to self or others ☐ Catatonia

☐ Other somatic treatment could potentially harm the member due to slower onset of action *(explain below)*

**The benefits of ECT outweigh the risk of other treatment as evidences by at least one of the following:**

☐ Customer **or** family member has had a history of positive response to ECT

| Date | Provider | Number of treatments | Response |
|---|---|---|---|
| | | | |
| | | | |

☐ Member has not responded to adequate medication trials *(At least 2 trials of Antidepressants)*

| Medication Name(s) | Medication Class | Max Dose | Time Period | Response | Side effects | Current Med |
|---|---|---|---|---|---|---|
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |

| Is the customer pregnant? | Is the customer 18 years of age or older? | Has Informed consent been obtained? |
|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

| ECT Determination: #____ of treatments requested # ____Denied # ___ Approved |
|---|
| Physician Signature & Date: |

## 12.04B Request for Additional ECT Treatments

| Patient Name: | DOB: | SmartCare ID#: |
|---|---|---|
| Provider/Facility: | Provider/Facility Phone #: | |
| Anticipated Start Date: | Anticipated End Date: | |
| Requested Number of Sessions: | Frequency of Sessions: | |
| Level of Care for ECT: ☐ Inpatient ☐ Outpatient | Psychiatrist Name Requesting: | |
| Outpatient Psychiatrist Name: | | |

| **All of the following must be met:** | **Yes** | **No** |
|---|---|---|
| The customer is in agreement to continue ECT Treatments | ☐ | ☐ |
| The customer continues to meet admission criteria for ECT | ☐ | ☐ |
| An alternative treatment would not be more appropriate to address the members ongoing symptoms | ☐ | ☐ |
| Treatment is still necessary to reduce symptoms and improve functioning | ☐ | ☐ |
| There is evidence of subjective progress in relation to specific symptoms or treatment plan has been modified to address a lack of progress | ☐ | ☐ |
| The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects | ☐ | ☐ |
| There is documented coordination with family and community supports as clinically appropriate | ☐ | ☐ |
| Medication assessment has been complete when appropriate and medication trials have been initiated or ruled out | ☐ | ☐ |

| **Description of continued need, addressing question responses above:** |
|---|
| |

| ECT Determination: # of treatments requested # Denied # Approved |
|---|
| Physician Signature & Date: |