



Section: <b>Clinical Practices</b>	Procedure Name: <b>Electroconvulsive Therapy Authorizations</b>	Procedure #: <b>P12.04.01</b>
Overarching Policy: <b>12.04 Electroconvulsive Therapy</b>		
Owner: <b>Director of Utilization Management</b>	Reviewed By: <b>Elizabeth Guisinger, LPC, CAADC Perry Westerman, MD</b>	Total Pages: <b>4</b>
Required By: <input type="checkbox"/> BBA <input type="checkbox"/> MDHHS <input type="checkbox"/> NCQA <input checked="" type="checkbox"/> Other (please specify): <b>See References</b>	Final Approval By:  <small>Beth Guisinger, Jun 15, 2023 16:31 EDT</small>  <small>Perry Westerman M.D., (Jun 16, 2023 14:30 EDT)</small>	Date Approved: <b>Jun 15, 2023</b>
Application: <input checked="" type="checkbox"/> SWMBH Staff/Ops <input checked="" type="checkbox"/> Participant CMHSPs <input type="checkbox"/> SUD Providers <input checked="" type="checkbox"/> MH/IDD Providers <input type="checkbox"/> Other (please specify): _____	Line of Business: <input checked="" type="checkbox"/> Medicaid <input type="checkbox"/> Other (please specify): _____ <input checked="" type="checkbox"/> Healthy Michigan _____ <input type="checkbox"/> SUD Block Grant <input type="checkbox"/> SUD Medicaid <input type="checkbox"/> MI Health Link	Effective Date: <b>11/14/2016</b>

**Policy:** No customer of Southwest Michigan Behavioral Health (SWMBH) shall be the subject of 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 Electroconvulsive Therapy (ECT) and describe a clear method for completing authorization service determinations for customers of SWMBH and the participant Community Mental Health Service Providers (CMHSPs). This will support and enhance the overall goal of improving care under the standards of best practice and adhere to regulatory requirements and contractual obligations.

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



A board-certified psychiatrist will provide determinations on outpatient and/or inpatient ECT authorization requests.

**Definitions:** Electroconvulsive Therapy (ECT): ECT applies electrical stimuli to the brain via scalp electrodes to induce seizures. It is administered under general anesthesia and may be performed in an inpatient or outpatient settings. This treatment has been beneficial when others attempted have been unsuccessful.

**Procedures:**

- A. Upon receipt of an initial request for Electroconvulsive Therapy by the CMHSP's UM Department for outpatient or by SWMBH's UM Department for psychiatric hospitalization requests:
  - 1. UM staff will consult with a board-certified psychiatrist to determine if medical necessity criteria is met for admission/initial authorization of ECT as outlined in SWMBH Policy 12.04 Electroconvulsive Therapy.
  - 2. SWMBH clinical UM staff will complete the 'SWMBH ECT Request' form for psychiatric hospitalization requests, and review with a board-certified psychiatrist for an authorization determination. Any additional clinical documentation will be presented with the 'SWMBH ECT Request' form. CMHSPs may use the 'SWMBH ECT Request' form for outpatient ECT requests; however, use of this is not mandatory, if documentation is sufficient.
  - 3. If the request appears to place the reviewing psychiatrist in a situation where determining the request could present a real or perceived conflict of interest, clinical UM staff will contact the external review organization for review and recommendation by another board-certified psychiatrist, who is licensed to practice in the state of Michigan. For CMHSPs looking for an external review, SWMBH's Medical Director may be utilized if no conflict of interest exists.
  - 4. The SWMBH Medical Director, or contracted psychiatrist, will consult with the requesting psychiatrist, if necessary, to make an authorization determination.
  - 5. This determination will be provided to clinical UM staff by the psychiatrist making the determination, along with clear rationale for the determination. This information will be documented in the client's master record. Authorizations requested, approved and/or denied will be reflected in the authorization document.
  - 6. The psychiatrist who reviewed the authorization request will make any determinations that result in a medical necessity denial.
- B. Upon SWMBH UM Staff's receipt of an authorization request for continued Electroconvulsive Therapy:
  - 1. If the request is within the maximum number ECT treatments that was previously approved by the board-certified psychiatrist during the initial request. UM staff will complete the "Request for Additional ECT Treatments" form and upload the documentation into the customer's master record if medical necessity criteria is met for continued authorization of ECT as outlined in SWMBH Policy 12.4 Electroconvulsive Therapy. UM staff will enter the additional authorized ECT treatments in the MCIS, when applicable.
  - 2. If the request is to extend beyond the previously approved number by the psychiatrist of eight (8) for the initial series or maintenance treatments beyond either eight (8) treatments or six (6) months duration, the SWMBH UM staff will complete the "Request for Additional ECT Treatments"



form and will communicate the request, along with the clinical information provided, to a board-certified psychiatrist. SWMBH clinical staff will document said request in the MCIS. CMHSP UM staff may utilize the 'Request for Additional ECT Treatments' form, however, use of this is not mandatory, if submitted documentation is sufficient.

3. If the request appears to place the reviewing psychiatrist in a situation where determining the request could present a real or perceived conflict of interest, clinical UM staff will contact the external review organization for review and recommendation by another board-certified psychiatrist, who is licensed to practice in the state of Michigan. For CMHSPs looking for an external review, SWMBH's Medical Director may be utilized if no conflict of interest exists.
4. The psychiatrist will consult with the psychiatrist requesting ECT on behalf of the customer, if necessary, to make an authorization determination.
5. This determination will be provided to clinical UM staff by the psychiatrist making the determination, along with clear rationale for the determination. This information will be documented in the client's master record. Authorizations requested, approved and/or denied will be reflected in the authorization document.

**Effectiveness Criteria:** All ECT authorizations have been staffed with a psychiatrist for determination.

All supporting clinical documentation has been uploaded to the customer file in MCIS/EMR to indicate appropriateness of treatment based on medical necessity criteria.

**References:** Michigan Mental Health Code, Act 258 of 1974, 330.1717  
MDHHS AR 330.7017  
MCG Electroconvulsive Therapy (ECT) (B-802-T), 26<sup>th</sup> Edition

**Attachments:**

- A. P12.04.01A SWMBH ECT Request Form
- B. P12.04.01B Request for Additional ECT Treatments Form



**Revision History**

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	6/9/2020	Procedure removed from policy	Procedure removed from policy	E. Guisinger
1	5/17/2022	Effective Date References to MCG Attachments	Updated date to reflect original effective date of 11/14/2016 after previously being entered incorrectly on updated template. Updated to MCG medical necessity criteria. Archived 12.04A&B attachments and replace with 12.04.01A&B	E. Guisinger
2	5/1/2023			E. Guisinger










# P12.04.01 Electroconvulsive Therapy Authorizations

Final Audit Report

2023-06-16

Created:	2023-06-15
By:	Megan O'Dea (megan.odea@swmbh.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAdj1-ZY3mN0RExHSMKu5A2oQg2-6zQgZf

## "P12.04.01 Electroconvulsive Therapy Authorizations" History

-  Document created by Megan O'Dea (megan.odea@swmbh.org)  
2023-06-15 - 8:21:47 PM GMT
-  Document emailed to Beth Guisinger (beth.guisinger@swmbh.org) for signature  
2023-06-15 - 8:22:17 PM GMT
-  Email viewed by Beth Guisinger (beth.guisinger@swmbh.org)  
2023-06-15 - 8:31:09 PM GMT
-  Document e-signed by Beth Guisinger (beth.guisinger@swmbh.org)  
Signature Date: 2023-06-15 - 8:31:16 PM GMT - Time Source: server
-  Document emailed to perry.westerman@swmbh.org for signature  
2023-06-15 - 8:31:17 PM GMT
-  Email viewed by perry.westerman@swmbh.org  
2023-06-16 - 6:30:15 PM GMT
-  Signer perry.westerman@swmbh.org entered name at signing as Perry Westerman M.D.  
2023-06-16 - 6:30:53 PM GMT
-  Document e-signed by Perry Westerman M.D. (perry.westerman@swmbh.org)  
Signature Date: 2023-06-16 - 6:30:55 PM GMT - Time Source: server
-  Agreement completed.  
2023-06-16 - 6:30:55 PM GMT





12.04.01A 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: <input type="checkbox"/> Inpatient <input type="checkbox"/> 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
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>

Is the customer pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the customer 18 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has Informed consent been obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---

ECT Determination: # \_\_\_\_\_ of treatments requested      # \_\_\_\_\_ Denied      # \_\_\_\_\_ Approved

Physician Signature & Date: \_\_\_\_\_







**12.04.01B Additional 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: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Psychiatrist Name Requesting:	
Outpatient Psychiatrist Name:		

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

<b>Description of continued need, addressing question responses above:</b>

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

