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Section: **Clinical Practices**	Procedure Name: **Electroconvulsive Therapy Authorizations**	Procedure #: **P12.04.01**
Overarching Policy: **12.04 Electroconvulsive Therapy**		
Owner: **Manager of UM & Call Center**	Reviewed By: **Elizabeth Guisinger, LPC, CAADC** **Bangalore Ramesh, MD**	Total Pages: **5**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☒ **Other (please specify):** **See References**	Final Approval By: *Elizabeth Guisinger* Elizabeth Guisinger (Jun 12, 2020 11:13 EDT) *B K Ramesh* B K Ramesh (Jun 15, 2020 14:31 EDT)	Date Approved: Jun 12, 2020
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☐ **SUD Providers** ☒ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☒ **Medicaid** ☒ **Healthy Michigan** ☐ **SUD Block Grant** ☐ **SUD Medicaid** ☐ **MI Health Link** ☐ **Other (please specify):** _____	Effective Date: **6/9/2020**

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 describing 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 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.

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Definitions: Electroconvulsive Therapy (ECT): 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.

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 Medical Director or other board-certified psychiatrist to determine if medical necessity criteria is met for admission/initial authorization of ECT as outlined in SWMBH Policy 12.4 Electroconvulsive Therapy
   2. SWMBH clinical UM staff will complete the 'SWMBH ECT Request' form for psychiatric hospitalization requests, and review with the SWMBH Medical Director 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, as long as documentation is sufficient.
   3. If the request appears to place the Medical Director in a situation where making a determination on the request could present a real or perceived conflict of interest, clinical UM staff will contact the external review organization for review and determination by a 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. Said 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 Medical Director, or contracted 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 for over the eight (8) initial or six (6) maintenance ECT treatments that were previously approved by the psychiatrist, 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 the Medical Director. 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, as long as documentation is sufficient.

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3. If the request appears to place the Medical Director in a situation where making a determination on the request could present a conflict of interest, clinical staff will contact the external review organization for review and determination by a 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 psychiatrist requesting ECT on behalf of the customer, if necessary, to make an authorization determination.
5. This determination will be provided to clinical staff by the psychiatrist making the determination, along with clear rationale for the determination. Said information will be documented in the client's master record. Authorizations requested, approved and/or denied will be reflected in the authorization document. The Medical Director or contracted psychiatrist who reviewed the authorization request, will make any determinations that result in a medical necessity denial.

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 indicating appropriateness of treatment based on medical necessity criteria.

References: Public Act 258, Michigan Mental Health Code MCL 330.1717
MDHHS AR 330.7017
SWMBH Medical Necessity Criteria (Adopted Beacon Health Options Medical Necessity Criteria: 6.601.0 Electroconvulsive Therapy

Attachments:
A. SWMBH ECT Request Form
B. Request for Additional ECT Treatments Form

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Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
Initial	6/9/2020	Procedure removed from policy	Procedure removed from policy	E. Guisinger

P12.04.01 Electroconvulsive Therapy

Final Audit Report 2020-06-15

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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: ☐ 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:

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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: ☐ 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:						