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Policy Name	Electroconvulsive Therapy (ECT) - 2024
Policy Number	20.5.002
Issued By	Chief Medical Officer
Approved By	Corporate Quality Improvement Committee
Original Effective Date	08/21
Revision Dates	09/22
Review Dates	11/21, 09/23

Purpose

To provide authorization parameters for benefit approval of Electroconvulsive Therapy so that benefit decisions are applied in a consistent and relevant fashion.

Definitions

Electroconvulsive therapy (ECT) was developed in 1938 and has been continuously refined in the intervening years. ECT uses an alternating current applied to the scalp to induce a seizure. Advances have included improvements in the devices to deliver the stimulus, stimulus parameter changes, introduction and advances in anesthesiology, addition of muscle relaxants, etc. The direct application of electricity to neurons via the scalp results in a seizure, causing significant changes in neuron function, both in the acute phase and in a prolonged fashion after the stimulation ends. The major therapeutic impact of ECT is the improvement in certain symptoms, such as mood disorder, psychosis, or suicidality.

Scope

This policy applies to all Workforce Members of Lucet involved in clinical services, and Providers that service Lucet's Members. This policy applies to benefits administered in plan year 2024.

Policy

A. Expectations of Care Delivery
    1. The primary attending physician is a psychiatrist, trained and credentialed to administer ECT. The attending is responsible for diagnostic evaluation and provides face -to-face services with documentation.
    2. Meets all state laws and regulations regarding the practice of ECT.
    3. The family/support system is educated as to the practice of ECT, including post- discharge care during a course of ECT treatment with attention to restrictions on daily activities, as well as the likely need for continuation of ECT on an outpatient basis, including transportation issues.

4. The FDA has granted approval for the use of ECT devices for those individuals 13 and older. For adolescents, particular attention to informed consent must be maintained. There is no upper age limit for ECT. As many states have regulations regarding the use of ECT, the attending and facility must abide by these.
5. ECT is typically administered at either an inpatient or outpatient facility level of care. In certain circumstances, ECT may also be appropriate for a member at a Residential level of care. In this situation, the ECT treatment would likely be rendered at an outpatient facility.
6. The total number of ECT treatments in a series is typically six (6) to twelve (12). Total treatment number should be dictated by the clinical situation.

B. Initial Authorization Requirements
   1. ECT is considered medically necessary for approval of twelve (12) units of CPT code 90870 when the Initial Authorization Requirements are met.
      a. **Must meet all of the following, i through vi:**
         i. Must have one of the following DSM diagnoses, which is the primary focus of ECT treatment:
            1) Major Depressive Disorder: single or recurrent; severe, psychotic, or non-psychotic
            2) Bipolar Disorder: depressed, mixed, manic
            3) Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
            4) Catatonia
            5) Neuroleptic Malignant Syndrome
         ii. There is a reasonable expectation of reduction in the severity of the current condition and behaviors with ECT.
         iii. A complete diagnostic psychiatric evaluation is completed prior to initiation of ECT.
         iv. Must meet one of the following:
            1) ECT initiation requests require documentation of two or more adequate trials of full dose antidepressants (adequate time = eight (8) weeks). Augmentation with lithium, thyroid or atypical antipsychotics has been tried or considered. Alternative indication is the inability to tolerate medication due to serious side effects. Note: Acute treatment frequency for ECT is typically three (3) to five (5) times per week.
            2) The member is markedly impaired by his/her psychiatric illness, so that serious physiological or physical complications are very likely.
            3) History of a significant prior response to ECT
         v. The frequency of ECT treatments is typically three times weekly.
         vi. The member or guardian provides informed consent of ECT and is educated concerning the risks and benefits.

C. Continued Authorization Requirements
    1. **Must meet all of the following**:
        a. Must have one of the following DSM diagnoses, which is the primary focus of ECT treatment:
            i. Major Depressive Disorder: single or recurrent; severe, psychotic, or non-psychotic
            ii. Bipolar Disorder: depressed, mixed, manic
            iii. Schizophrenia/Schizophrenia Spectrum/Schizoaffective/Psychotic Disorders
            iv. Catatonia
            v. Neuroleptic Malignant Syndrome
        b. There is compliance with all aspects of the treatment plan, unless clinically precluded.
        c. There is a reasonable expectation of improvement in the current condition and behaviors with continued ECT.
        d. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to terminate the ECT series. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms.

D. Requests for Continuation ECT
    1. This refers to ECT treatments provided after the index series of treatments for a period of up to six (6) months to individuals in remission. The treatment is generally administered on an outpatient basis. Although the medical literature evidence is limited as to the efficacy of Continuation ECT, relapse rates after the index course are substantial. The treatment frequency typically starts out at weekly and then gradually reduces to monthly or longer, as long as the member is clinically stable. Conceptually, it is designed to prevent relapse.
        a. **Must meet all of the following**:
            i. The attending psychiatrist performs:
                1) an assessment of current symptoms and medications
                2) determine the need for Continuation ECT
                3) determine the timing and frequency of treatments
            ii. The member has shown an adequate response to the index episode of ECT.
            iii. The member expresses a preference to continuation ECT OR the member is intolerant to pharmacotherapy.
            iv. The member or guardian provides informed consent of Continuation ECT and is educated concerning the risks and benefits.

E. Requests for Maintenance ECT

1. This refers to ECT treatment delivered prophylactically after the six (6) month period of Continuation ECT. Treatment is almost exclusively provided as an outpatient There is limited medical literature evidence as to the efficacy of Maintenance ECT, and conceptually it is considered to prevent recurrence. The treatment frequency depends upon what is required to prevent recurrence. There is no evidence as to how long Maintenance ECT should be administered.
    a. **Must meet all of the following**:
        i. The attending psychiatrist performs:
            1) an assessment of current symptoms and medications
            2) determine the need for Maintenance ECT
            3) determine the timing and frequency of treatments
        ii. The member has shown an adequate response to the continuation of ECT.
        iii. The member has a marked history of relapse and recurrence OR the member has a history of significant symptom increases when Continuation ECT was tapered.
        iv. The member expresses a preference for Maintenance ECT OR the member is intolerant to pharmacotherapy.
        v. The member or guardian is provided informed consent of Maintenance ECT and is educated concerning the risks and benefits.

Exceptions

Exceptions to this policy must be approved by Chief Medical Officer or their designee.

References

American Psychiatric Association. The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging, APA. Washington, DC, 2001.

Espinoza RT, Kellner CH. Electroconvulsive Therapy. N Engl J Med. 2022 Feb 17;386(7):667-672. doi: 10.1056/NEJMra2034954. PMID: 35172057.

Food and Drug Administration. Neurological Devices; Reclassification of Electroconvulsive Therapy Devices; Effective Date of Requirement for Premarket Approval for Electroconvulsive Therapy Devices for Certain Specified Intended Uses. Final order. Fed Regist. 2018; 83:66103-66124.

Kirov G, Jauhar S, Sienaert P, Kellner CH, McLoughlin DM. Electroconvulsive therapy for depression: 80 years of progress. Br J Psychiatry. 2021 Nov;219(5):594-597. doi: 10.1192/bjp.2021.37. PMID: 35048827.

Mi Jin Park, et.al. Recent Updates on Electro-Convulsive Therapy in Patients with Depression. Psychiatry Investig. 2021 Jan; 18(1): 1–10. Published online 2021 Jan 19. doi: 10.30773/pi.2020.035

Sanghani SN, Petrides G, Kellner CH. Electroconvulsive therapy (ECT) in schizophrenia: a review of recent literature. Curr Opin Psychiatry. 2018; 31:213-222.

Related Documents

POLICIES
N/A

PROCEDURES
N/A

FORMS
N/A