REQUEST FOR CONTINUATION OR MAINTENANCE OUTPATIENT ELECTROCONVULSIVE THERAPY (ECT)

Form only applies to continuation and maintenance outpatient ECT treatment.

General Instructions:

- All Member information (Member’s Name, Date of Birth, Insurance ID Number, Member's Phone Number) must be completed, or form will be returned.
- Type or print neatly in the designated fields.
- Complete all applicable fields.
- Write the numerical diagnosis code(s) from the DSM-5 or ICD-10.

Authorization is not required for:

- BCBS Alabama (Except Lowe's)
- BCBS Arkansas (Except for FEP)
- BCBS Kansas
- Walmart

Return via fax to the appropriate fax number:

- Lucet Employee: 816-416-7788

  If your client is covered as an employee of Lucet or a spouse or dependent of a Lucet employee, please return by fax to our Internal Behavior Health Benefit Review team.
- 816-237-2364
  - BCBS Alabama (Lowe's)
  - BCBS Arkansas (FEP)
  - BCBS Florida (Florida Blue)
  - BCBS Kansas City (Blue KC)
  - BCBS Louisiana
  - Imperial
  - SCAN

Note: For verification of benefits, eligibility, authorization requirements, and allowable codes, please call the customer service number listed on the member’s insurance ID card.

Medical policy information is available at Lucethealth.com under Medical Necessity Criteria.

CONTINUATION OR MAINTENANCE OUTPATIENT ECT TREATMENT REQUEST FORM

Member's Information
Name: ____
Insurance Policy #: __________________
Date of Birth: _____________ Phone #: ________________
Authorization #: ______________

Check the applicable box below to attest that the criteria have been met:

☐	Continuation – Must meet all of the following: 1. The attending psychiatrist performs: i. An assessment of current symptoms and medications. ii. Determine the need for Continuation ECT. iii. Determine the timing and frequency of treatments. 2. The member has shown an adequate response to the initial episode of ECT. 3. The member expresses a preference to continuation ECT OR the member is intolerant to pharmacotherapy. 4. The member or guardian provides informed consent of Continuation ECT and is educated concerning the risks and benefits.
☐	Maintenance Must meet all of the following: 1. The attending psychiatrist performs: i. An assessment of current symptoms and medications. ii. Determine the need for Maintenance ECT. iii. Determine the timing and frequency of treatments. 2. The member has shown an adequate response to the continuation of ECT. 3. 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. 4. The member expresses a preference for Maintenance ECT OR the member is intolerant to pharmacotherapy. 5. The member or guardian provides informed consent of Maintenance ECT and is educated concerning the risks and benefits.

☐ **PLEASE CHECK THIS BOX TO ATTEST TO THE FACT THAT ALL OF THE INFORMATION PROVIDED IS ACCURATE AND REFLECTED IN THE PATIENT'S MEDICAL RECORD.**

For ECT request found to be medically necessary, the following CPT codes and units will include, as applicable:
00901 – Electroconvulsive Therapy Facility (Facility)
90870 – Electroconvulsive Therapy Treatment and Monitoring (Psychiatrist)
Continuation: 6 units / 6 months
Maintenance: 24 units / 1 year