UTILIZATION MANAGMENT			
	APSHealthCare.	**Effective Date** 12/29/2023	**Owner** VP Medical Affairs
		Policy Number UM 16	**Most Recent Revision Date** 04/30/2024
	Electroconvulsive Therapy (ECT) Medical Necessity Guidelines	**Annual Reviews (Past 3 yrs.)**	**Approved By** VP Medical Affairs
			Regulatory Elements
	Applicable Products: ☐Medicaid	☒Medicare	☐Commercial
	Approvers Name (Printed): Jose L. Massa, MD		
	Approver's Signature: 		
	References: Electroconvulsive Therapy (ECT) ORG: B-802-T (BHG). MCG Health Behavioral Health Care Guideline 27th Edition. American Psychiatric Association. (2010). The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging (2nd ed.). American Psychiatric Publishing. The Joint Commission. (2024). Standards for Behavioral Health Care. JointCommission.org.		

1.0 POLICY

1.1 The APS UM Committee, chaired by the VP of Medical Affairs, aims to deliver quality, cost-effective healthcare for our beneficiaries.

1.2 This policy outlines the criteria and process for the prospective review of Electroconvulsive Therapy (ECT) services to ensure they meet the established guidelines by the Centers for Medicare & Medicaid Services (CMS). The aim is to ensure that ECT services are medically necessary, appropriately utilized, and provided in a manner that is consistent with current clinical standards and CMS regulations.

1.3 This policy applies to all healthcare providers and entities involved in the provision, authorization, and review of ECT services under the jurisdiction of CMS guidelines.

1.4 All ECT services must be reviewed prospectively to determine their medical necessity and appropriateness according to the CMS guidelines. The utilization management process will ensure that ECT is provided to patients who meet the specific criteria set forth by CMS and is performed in a manner that upholds the highest standards of patient care and safety.

1.5 This guideline supports our team and offers the latest evidence-based information from nationally recognized organizations for service requests under UM review.

1.6 This does not aim to dictate providers' practices; they serve as references.

1.7 This guideline does not supersede state or federal law or regulation, including Medicare National or Local Coverage Determinations as applicable.

1.8 For jurisdictions with no Medicare guidance on a specific level of care or service, APS will utilize generally accepted guidance based on prevailing medical practice standards and clinical guidelines supporting our determinations regarding specific services in conjunction with adhering to Medicare's reasonable and necessary requirement such as the MCG Guidelines.

1.9 In interpreting or supplementing the criteria above and in order to determine medical necessity consistently, APS uses MCG Guidelines.

1.10 Healthcare providers are expected to offer evidence-based care, respecting patient autonomy, and considering the least restrictive, evidence-based options.

1.11 Healthcare providers must assess the suitability of these guidelines in individual patient scenarios with a patient-centered approach.

1.12 Guidelines do not endorse specific services and are designed to provide information and assist decision making.

1.13 They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course in management. The APS UM Committee retains the right to update these guidelines as the field progresses.

1.14 CMS rule includes provisions related to Non-Quantitative Treatment Limitations (NQTLs) under the Mental Health Parity and Addiction Equity Act (MPHEA).

1.14.1 For electroconvulsive therapy, the CMS rule specifies that the payment per treatment is subject to annual updates. The rule ensures that ECT, like other psychiatric treatments, adheres to the principles of medical

necessity and active treatment aimed at improving the patient's psychiatric condition.

2.0 ELECTROCONVULSIVE THERAPY OVERVIEW

2.1 Electroconvulsive therapy (ECT) applies electrical stimuli to the brain via scalp electrodes to induce seizures. It is administered under general anesthesia and may be performed in either inpatient or outpatient settings.

2.2 The risks of ECT are primarily those associated with anesthesia, so pretreatment medical review is required. Cognitive dysfunction, including disorientation and anterograde and retrograde amnesia, is the most significant side effect.

2.3 ECT is not recommended for patients with active cardiac disease (e.g., myocardial ischemia, arrhythmia), cerebrovascular disease (e.g., cerebral hemorrhage, stroke), or increased intracranial pressure (e.g., due to space-occupying lesion) due to an increased risk of periprocedural complications. Offers intensive outpatient care for profound mental health conditions.

3.0 ELECTROCONVULSIVE THERAPY CRITERIA

3.1 Electroconvulsive therapy (ECT) for:

- 3.1.1 Rapid treatment, as indicated by:
  - 3.1.1.1 Diagnosis of a mental disorder that can benefit from electroconvulsive therapy, as indicated by:
    - 3.1.1.1.1 Major depressive disorder, severe, with or without psychotic features
    - 3.1.1.1.2 Bipolar disorder, severe, with manic or depressive episodes, with or without psychotic features.
    - 3.1.1.1.3 Schizophrenia or schizoaffective disorder, particularly when symptoms are severe and resistant to other treatments.
- 3.1.2 Lack of Response to Other Treatments:
  - 3.1.2.1 Documented failure of, or contraindications to, an adequate trial of pharmacotherapy and/or psychotherapy.
  - 3.1.2.2 Evidence of partial response to pharmacotherapy or psychotherapy, with persistent significant impairment.
  - 3.1.2.3 Pharmacotherapy not preferred due to risk of adverse effects (e.g., pregnancy or elderly patients) or documented intolerance)
  - 3.1.2.4 Impulsive self-injurious behavior
  - 3.1.2.5 Symptoms prior to treatment are qualified as severe.
  - 3.1.2.6 Patient has undergone medical review and clearance.

3.1.3 Need for ECT, as indicated by:

3.1.3.1 Rapid Response Requirement:

3.1.3.2 Situations where rapid symptom resolution is necessary due to the severity of the condition (e.g., life-threatening depression, acute mania).

3.1.3.3 The presence of severe suicidal ideation or behavior, catatonia, or other critical symptoms that pose is qualified as an immediate risk of danger.

3.1.4 Extension of acute treatment, as indicated by;

3.1.4.1 Sub-therapeutic response to current and immediate treatment

3.1.4.2 Ongoing evaluation and adjustment of treatment to secure effective treatment.

3.1.5 Continuity of treatment on an alternative less intensive level of care (e.g. outpatient care) as indicated by:

3.1.5.1 Treatment is needed to reduce the risk of relapse.

3.1.5.2 Additional pharmacotherapy adjusted as required, or recorded intolerance or inadequate medication response.

3.1.5.3 Electroconvulsive therapy sessions adjusted to the lowest effective frequency (e.g., weekly, biweekly, monthly).

3.1.6 Patient's Health and Safety:

3.1.6.1 Electroconvulsive therapy is likely to result in considerable progress in the patient's condition suitable for this treatment.

3.1.6.2 The benefits of ECT outweigh the potential risks, as assessed by a qualified mental health professional.