NMNC 6.601.05 Electro-Convulsive Therapy

Electro-Convulsive (ECT) Therapy is a procedure in which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity while the member is under general anesthesia. This procedure can be administered in a variety of settings, ranging from a licensed hospital to outpatient settings. The decision to pursue ECT treatment is based on a risk/benefit analysis of the member's history, medical issues, symptomatology, and anticipated adverse side effects. Providers must complete a work-up, including medical history, physical examination, and any indicated pre-anesthetic lab work to determine whether there are contraindications to ECT-related anesthesia and that there are no less intrusive alternatives before scheduling administration of ECT. The member must, as required by state- or federal-specific requirements, provide separate written informed consent to ECT on forms provided by the specific state mental health agency, as consent to other forms of psychiatric treatment are considered separate. The member should be fully informed of the risks and benefits of this procedure and of any alternative somatic or non-somatic treatments.

In general, an acute course of ECT will consist of three sessions per week, for a total of 6 to 12 sessions. For members who achieve remission with ECT but are not able to maintain remission with pharmacotherapy, ECT may be administered as a maintenance treatment and is provided at a reduced frequency (e.g., weekly, biweekly, monthly). Maintenance ECT may be indicated for long-term maintenance when there is evidence that discontinuation or reduction in frequency is likely to result in a relapse.

Admission Criteria	Continued Stay Criteria	Discharge Criteria
***All* of the following criteria must be met:** 1) *DSM* or corresponding ICD diagnosis of major depressive disorder, schizophrenia, schizoaffective disorder, or other disorder with features that include mania, psychosis, and/or catatonia 2) Member has been medically cleared and there are no contraindications to ECT (i.e., intracranial, cardiovascular, or pulmonary contraindications) 3) There is an immediate need for rapid, definitive response due to **at least one** of the following: a) significant risk of harm to self or others; or b) catatonia; or c) intractable manic episode; or d) other treatments could potentially harm the member due to slower onset of action 4) The benefits of ECT outweigh the risks of other treatments as evidenced by **at least one** of the following: a) member has not responded to adequate medication trials; or b) member has had a history of positive response to ECT 5) Maintenance ECT, as indicated by **all** of the following:	***All* of the following criteria must be met:** 1) Member continues to meet admission criteria 2) An alternative treatment would not be more appropriate to address the member's ongoing symptoms 3) Member is in agreement to continue treatment of ECT 4) Treatment is still necessary to reduce symptoms and improve functioning 5) There is evidence of subjective progress in relation to specific symptoms, or treatment plan has been modified to address a lack of progress 6) The total number of treatments administered is proportional to the severity of symptoms, rate of clinical improvement, and adverse side effects 7) There is documented coordination with family and community supports as clinically appropriate 8) Medication assessment has been completed when	**Any *one* or more of the following criteria must be met**: 1) Member no longer meets admission criteria and/or meets criteria for another level of care, either more or less intensive; or 2) Member withdraws consent for treatment or refuses treatment and does not meet criteria for involuntary mandated treatment; or 3) Member is not making progress toward goals, nor is there expectation of any progress; or 4) Member's individual treatment plan and goals have been met; or

a) Without maintenance ECT member is at risk of relapse b) Adjunct therapy to pharmacotherapy c) Sessions tapered to lowest frequency that maintains baseline	appropriate and medication trials have been initiated or ruled out	5) Member's natural support (or other support) systems are in agreement with following through with member care, and the member is able to be in a less restrictive environment

Exclusions

Any **one** of the following criteria is sufficient for exclusion from this level of care*:*

1) Member can be safely maintained and effectively treated with a less intrusive therapy; or
2) Although there are no absolute medical contraindications to ECT, there are specific conditions that may be associated with substantially increased risk and therefore may exclude a specific individual from this level of care. Such conditions include but are not limited to:
   a) Unstable or severe cardiovascular conditions such as recent myocardial infarction, congestive heart failure, and severe valvular cardiac disease
   b) Aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure
   c) Increased intracranial pressure, as may occur with some brain tumors or other space-occupying lesions
   d) Recent cerebral infarction
   e) Pulmonary conditions, such as severe chronic obstructive pulmonary disease, asthma, or pneumonia
   f) Anesthetic risk rated as American Society of Anesthesiologists levels 4 or 5.

Reference Sources

Beacon's Medical Necessity Criteria incorporate generally accepted standards of behavioral health practice documented in evidence- and consensus-based guidelines derived from:

1) Professional societies: American Psychiatric Association (APA)
2) National care guideline and criteria entities: MCG Care Guidelines
3) National health institutes: National Institutes of Health (NIH)
4) Professional publications and psychiatric texts: [Beacon's Publication Reference Table]
5) Federal/state regulatory and industry accreditation requirements, including CMS's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
6) National industry peer organizations, including managed care organizations (MCOs) and behavioral health organizations (BHOs)