



Electroconvulsive Therapy (ECT)

Definition:

ECT is a mental health procedure used to treat medically stable individuals with mental illness who are drug resistant for treatment of some psychiatric disorders. Those disorders may include major depression, bipolar disorder and schizophrenia. The service must be provided in an appropriately equipped facility by a trained and experienced licensed psychiatrist in Oklahoma. This service may be delivered as a part of an inpatient hospital per diem as well as delivered as an outpatient procedure in an outpatient surgery environment.

Policy:

ECT mental health services are available to Medicaid Managed Care eligible adult members, age 21 and over and with exceptional circumstances under 21.

Authorizations:

ECT authorizations will be accomplished through a PA (Prior Authorization) process. The PA requests will be reviewed by OHCA psychiatrists. Any ECT PA denial would be reviewed by two Oklahoma Healthcare Authority psychiatrists.

Turnaround time for PA authorizations:

1. Inpatient: 24 business hours (working business hours are M-F, 8 a.m. to 5 p.m.).
2. Outpatient: 72 business hours.

Licensing:

A hospital license or appropriate license for a surgical center is required to provide this service.

Program Expectations:

This service is provided in an appropriately equipped, safe treatment environment that is staffed with skilled medical personnel to prepare the client for the procedure and assist the client in recovery following the delivery of the procedure. A hospital license or appropriate license for a surgical center is required to provide this service.

Staffing must include the following:

- Oklahoma-licensed Psychiatrist who is credentialed to provide ECT
- Oklahoma-licensed RN's or Advanced Practice Registered Nurse (APRN) working within their scope of practice
- Oklahoma-licensed anesthesiologist working within their scope of practice
- All providers must be contracted with OHCA in order to bill.

Length of Service:

Duration of the service must be medically necessary based upon the psychiatrist's assessment and client's response to the treatment and according to the treatment plan. Treatment is usually provided intermittently for a series which may include 2-3 ECT treatment units weekly. And usually does not exceed 20 per rolling calendar year. In exceptional rare circumstances, it may exceed 20 treatment units. In such a case, an additional PA would be required for additional units in excess of 20 units per rolling calendar year.

Billing:

Charges are included in the inpatient hospital per diem when the client is admitted to the hospital. The procedure may be billed as an outpatient hospital service when the client resides in the community. When billed as an outpatient service, psychiatric-related services are billed separate from the medical components of the procedure.

Prior to ECT initiation procedures (inpatient and outpatient) the following is required:

- (a) A thorough evaluation of the patient's psychiatric and physical status with review of pertinent laboratory findings shall be done within 30 days prior to the initiation of a course of ECT and shall be recorded in the patient's permanent medical record. Physical evaluation shall include a thorough neurological examination. Other determinations shall include, but not be limited to, the following:
 - (1) laboratory as appropriate to medical history and/or conditions, such as:
 - a. Complete blood count
 - b. Electrolytes
 - (2) X-rays as appropriate to medical history and/or conditions
 - (3) Electrocardiogram
 - a. Abnormalities reported or found in the neurological or cardiac evaluation shall be evaluated by a medical specialist in the appropriate field, such evaluation to be incorporated in writing into the patient's permanent record prior to initiation of ECT.

The major contraindications to the therapeutic use of ECT are as follows:

- (1) Absolute space-occupying intracranial pathology;
- (2) Relative, requiring clinical consideration:
 - a. Cardiovascular disease, including arrhythmias, myocardial disease, or coronary artery disease;
 - b. Diseases which render a patient likely to suffer hemorrhage, including peptic ulcers, subdural hematoma, and aortic aneurysm;
 - c. Degenerative diseases of the central nervous system;
 - d. Glaucoma although it is recognized that intraocular pressure is not increased by ECT, and is, in fact, reduced during the seizure period, medications used adjunctively to the treatment may result in increased intraocular pressure. For patients with glaucoma, consideration should be given to pretreatment with physostigmine;
 - e. Severe orthopedic disability.

Clinical Guidelines: Outpatient Electroconvulsive Treatment

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for outpatient electroconvulsive therapy (ECT).

I. Severity of Need

Criteria A, B, C, D, E and F must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a DSM V or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, Major Depression, Bipolar Disorder, Mood Disorder with Psychotic Features, Catatonia, Schizoaffective Disorder, Schizophrenia, Acute Mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions such as pregnancy and medical disorders.
- B. The behavioral health symptoms are severe to include, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor and Neuroleptic Malignant Syndrome.
- C. Either;
 - The patient's symptoms lack response to adequate pharmacological interventions, including polypharmacy when indicated, for the diagnosis(es) and condition(s); or
 - The patient is has a co-morbid medical condition that prevents the use of available medications, such that efficacious treatment with medications is unlikely; or
 - The patient has a history of good response to ECT during an earlier episode of the illness, or
 - The patient is pregnant and has severe mania or depression, and the risks of providing psychiatric medications or no treatment outweigh the risks of providing ECT.

Outpatient:

1. The patient is medically stable and does not require the 24-hour medical/nursing monitoring or procedures provided in a hospital level of care.
2. The patient has access to a suitable environment and professional and/or social supports after recovery from the procedure, e.g., one or more responsible caregivers to drive the patient home after the procedure and provide post procedural care and monitoring, especially during the index ECT course.
3. The patient can be reasonably expected to comply with post-procedure recommendations that maintain the health and safety of the patient and others, e.g., prohibition from driving or operating machinery, complying with dietary, bladder, bowel, and medication instructions, and reporting adverse effects and/or negative changes in medical condition between treatments.
4. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity and Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

- A. There is documentation of a clinical evaluation performed by a psychiatrist who is credentialed to provide ECT, to include:
 - A clinical Summary of current mental disorders exacerbation that includes but is not limited to: Current and recent symptoms supporting indications for ECT, psychiatric history, including specific details evidence of past response to ECT, mental status and current functioning.
 - Medical history and examination focusing on neurological, cardiovascular and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.

- B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
- The patient's response to prior anesthetic inductions and any current anesthesia complications or risks.
 - Required modifications in medications or standard anesthetic technique.
- C. There is a medically necessary and appropriate individualized treatment plan, or its update, specific to the patient's psychiatric and/or medical conditions, that addresses:
- Specific medications to be administered during ECT, and
 - Choice of electrode placement during ECT, and
 - Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- D. There is continuous physiologic monitoring during ECT treatment, addressing:
- Seizure duration, including missed, brief and/or prolonged seizures, and
 - Electroencephalographic activity, and
 - Vital signs, and
 - Oximetry, and
 - Other monitoring specific to the needs of the patient.
- E. There is monitoring for and management of adverse effects during the procedure, including:
- Cardiovascular effects, and
 - Prolonged seizures, and
 - Respiratory effects, including prolonged apnea, and
 - Headache, muscle soreness and nausea.
- F. There are post-ECT stabilization and recovery services, including:
- Medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, and
 - Recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular

disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.

Criteria for Continued Treatment (Outpatient)

Criteria A, B, and C must be met to satisfy the criteria for continued treatment.

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
 - The persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; or
 - The emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I.; or
 - That attempts to discharge to a less intensive treatment will or can be reasonably expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

- B. The treatment plan allows for the lowest frequency of treatments that supports sustained remission and/or prevents worsening of symptoms.

- C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).

Inpatient Electroconvulsive Treatment

Clinical Guidelines: Inpatient Electroconvulsive Treatment

The specified requirements for severity of need and intensity and quality of service must be met to satisfy the criteria for inpatient electroconvulsive therapy (ECT)

I. Severity of Need

Criteria A, B, C, D, and E must be met to satisfy the criteria for severity of need.

- A. The clinical evaluation indicates that the patient has a DSM V Axis I diagnosis or condition that, by accepted medical standards, can be expected to improve significantly through medically necessary and appropriate ECT. Such diagnoses and conditions include, but are not limited to, Major Depression, Bipolar Disorder, Mood Disorder with Psychotic Features, Catatonia, Schizoaffective Disorder, Schizophrenia, Acute Mania, severe lethargy due to a psychiatric condition, and/or psychiatric syndromes associated with medical conditions such as pregnancy and medical disorders.
- B. The behavioral health symptoms are severe to include, but not limited to, high suicide or homicide risk, extreme agitation, life-threatening inanition, catatonia, psychosis, and/or stupor and Neuroleptic Malignant Syndrome.
- C. Either:
 - The patient's symptoms lack response to adequate pharmacological interventions. Including polypharmacy when indicated, for the diagnosis(es) and condition(s); or
 - The patient has a history of good response to ECT during an earlier episode of the illness, or

- The patient is pregnant and has severe mania or depression, and the risks of providing psychiatric medications or no treatment outweighs the risks of providing ECT.
- D. The patient and/or a legal guardian is able to understand the purpose, risks and benefits of ECT, and provides consent.

II. Intensity of Quality of Service

Criteria A, B, C, D, E, F and G must be met to satisfy the criteria for intensity and quality of service.

- A. There is documentation of a clinical evaluation performed by a psychiatrist who is credentialed to provide ECT, to include:
- A Clinical Summary of current mental disorder exacerbation that includes but is not limited to: Current and recent symptoms supporting indications for ECT, psychiatric history, including specific details evidence of past response to ECT, mental status and current functioning.
 - Medical history and examination focusing on neurological, cardiovascular, and pulmonary systems, current medical status, current medications, dental status, review of laboratory tests including electrocardiogram, if any, within 30 days prior to initiation of ECT.
- B. There is documentation of an anesthetic evaluation performed by an anesthesiologist or other qualified anesthesiology professional, to include:
- The patient's response to prior anesthetic inductions and any current anesthesia complications or risks.
 - Required modifications in medications or standard anesthetic technique.
- C. There is a medically necessary and appropriate individualized treatment plan, or its update, specific to the patient's psychiatric and/or medical conditions, that addresses:
- Specific medications to be administered during ECT.

- Choice of electrode placement during ECT.
 - Stimulus dosing using a recognized method to produce an adequate seizure while minimizing adverse cognitive side effects.
- D. There is continuous physiologic monitoring during ECT treatment, addressing:
- Seizure duration, including missed, brief, and/or prolonged seizures, and
 - Electroencephalographic activity, and
 - Electrocardiographic activity, and
 - Vital signs, and
 - Oximetry, and
 - Other monitoring specific to the needs of the patient
- E. There is monitoring for and management of adverse effects during the procedure, including:
- Cardiovascular effects, and
 - Prolonged seizures, and
 - Respiratory effects, including prolonged apnea, and
 - Headache, muscle soreness, and nausea.
- F. There are post-ECT stabilization and recovery services, including;
- Medically supervised stabilization services in the treatment area until vital signs and respiration are stable and no adverse effects are observed, and
 - Recovery services under the supervision of the anesthesia provider with continuous nursing observation and care; monitoring of vital signs including heart, respiration; pulse oximetry; electrocardiogram if there is cardiovascular disease or dysrhythmias are detected or expected. Electrocardiogram equipment should be continuously available in the recovery area. Recovery services should include treatment of postictal delirium and agitation, if any, including the use of sedative medications and other supportive interventions.
- G. The patient is released in the care of a responsible adult who can monitor and provide supportive care and who is informed in writing of post-procedure behavioral limitations,

signs of potentially adverse effects of treatment or deterioration in health or psychiatric status, and post-procedure recommendations for diet, medications, etc.

Criteria for Continued Treatment (Inpatient)

III. Continued Stay

Criteria A, B, and C must be met to satisfy the criteria for continued treatment.

- A. Despite reasonable therapeutic efforts, clinical findings indicate at least one of the following:
 - The persistence of problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outlined in I; or
 - The emergence of additional problems that meet the inpatient electroconvulsive treatment Severity of Need criteria as outline in I; or
 - That attempts to discharge to a less intensive treatment will or can be reasonable expected, based on patient history and/or clinical findings, to result in exacerbation or worsening of the patient's condition and/or status.

- B. The treatment plan allows for the lowest frequency of treatment that supports sustained remission and/or prevents worsening of symptoms.

- C. The treatment plan meets the Intensity and Quality of Service Criteria (II above).