Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Electroconvulsive Therapy (Outpatient)

<table>
<thead>
<tr>
<th>MNG #: 028</th>
<th>☒ SCO ☒ One Care</th>
<th>Prior Authorization Needed?</th>
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<tbody>
<tr>
<td>Clinical: ☒</td>
<td>Operational: ☐</td>
<td>Informational: ☐</td>
</tr>
<tr>
<td>Medicare Benefit: ☒ Yes ☐ No</td>
<td>Approval Date: 9/12/2019;</td>
<td>Effective Date: 4/25/2020</td>
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<td>Last Revised Date:</td>
<td>Next Annual Review Date: 9/12/2020;</td>
<td>Retire Date:</td>
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OVERVIEW:

Electroconvulsive therapy (ECT) is used to treat members who present treatment-resistant depression, mania or acute schizophrenia. The primary indication for the necessity of ECT is a major depressive disorder. ECT is administered by delivering an electrical current to the brain through the scalp in either a unilateral or bilateral manner to induce a generalized seizure.

ECT is considered as a treatment option when medications fail, cannot be tolerated or may be dangerous. This treatment is a first-line treatment for members who are severely depressed and require a rapid response because of a high suicide or homicide risk, extreme agitation, life-threatening inanition, psychosis or stupor. The average course of treatment is usually 6 – 12 treatments; some members may require up to 20 treatments. ECT is not an effective course of treatment for chronic schizophrenia. It may be effective for psychotic schizophrenic exacerbations when affective symptomatology is prominent, in catatonic schizophrenia or when there is a history of a prior favorable response to ECT.

DECISION GUIDELINES:

Treatment must be administered by a credentialed psychiatrist in a qualified acute care general hospital or acute care psychiatric hospital when the following conditions are met:

- Depression with acute suicide risk, extreme agitation and unresponsive to pharmacologic therapy.
- Intolerance to side effects of antidepressant medication or psychotropic medication that pose a medical risk.
- When rapid resolution of a depression is necessary (e.g., the member is acutely suicidal or physically compromised and the timeframe to achieve maximal effectiveness of antidepressants or mood stabilizers places the member at immediate risk to their health or safety).
- Inability to medically tolerate maintenance medication.
- Catatonia.
- **Acute** schizophrenia or life-threatening psychosis, which has not responded to or cannot be treated with short term, high dose tranquilization.
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Clinical Eligibility:
N/A

Determination of Medical Necessity:
N/A

LIMITATIONS/EXCLUSIONS:
ECT for the following conditions:

- Responsive to mood stabilizers.
- Ability to tolerate effective antidepressant or neuroleptic medications and a rapid resolution of depression is unnecessary because the member is not at immediate risk of suicide.
- Life-threatening psychosis responsive to short-term, high-dose tranquilization.
- No evidence of ECT effectiveness in members who have been treated previously.
- Maintenance ECT when pharmacotherapy was previously effective.
- Alcoholism as the primary diagnosis.
- To aid in developing conditioned aversions to the taste, smell, and sight of alcoholic beverages.
- No evidence of catatonia, acute schizophrenia, mania, suicide risk or extreme agitation.
- Medically inappropriate

KEY CARE PLANNING CONSIDERATIONS:
MD may approve with appropriate supporting documentation.

AUTHORIZATION:
The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not signify whether the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply. This Medical Necessity Guideline is subject to all applicable laws and regulations, Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider’s agreement with the Plan (including complying with Plan’s Provider Manual specifications).

Prior Authorization Requirements and Process:
- Number of treatments per week (not to exceed three times per week, for a prescribed duration).
- 90870 Electroconvulsive therapy (includes necessary monitoring)
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RELATED REFERENCES:
This MNG guide is not a rigid rule and shall be applied with the discretion of the supervising physician.

Centers for Medicare and Medicaid Services, National Coverage Determination (NCD): Multiple Electroconvulsive Therapy (MECT) (160.25).

1. Commonwealth of Massachusetts, Department of Mental Health, 104 CMR-58: Guidelines on the Administration of ECT.

ATTACHMENTS:

| EXHIBIT A: |  |
| EXHIBIT B: |  |

REVISION LOG:

<table>
<thead>
<tr>
<th>REVISION DATE</th>
<th>DESCRIPTION</th>
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<tr>
<td>9/12/2019</td>
<td>Reviewed and approved by Medical Policy Committee.</td>
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APPROVALS:

Peggy L. Johnson, MD  
CCA Senior Clinical Lead [Print]

Vice President and Chief of Psychiatry  
Title [Print]

Signature  
Date  
9/12/2019

CCA Senior Operational Lead [Print]

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Date