Outpatient Electroconvulsive Therapy (ECT)
PERFORMANCE SPECIFICATIONS

Performance Specifications (PS) Title: Outpatient Electroconvulsive Therapy (ECT)		
PS #: 016	**☒SCO ☒One Care** **☒ MA Medicare Premier** **☒ MA Medicare Value** **☒RI Medicare Preferred** **☒RI Medicare Value** **☒ RI Medicare Maximum**	**Prior Authorization Needed?** **☒Yes ☐ No**
Clinical: ☒	**Operational: ☐**	**Informational: ☐**
Medicare Benefit: **☒Yes ☐ No**	**Approval Date:** 10/14/2021;	**Effective Date:** 2/06/2022;
Last Revised Date: 4/19/2023;	**Next Annual Review Date:** 10/14/2022; 4/19/2024;	**Retire Date:**

COVERED SERVICES:

Electroconvulsive (ECT) Therapy is the initiation of generalized seizure activity with an electric impulse while the Member is placed under anesthesia. This procedure is administered in a hospital facility or community facility licensed to do so by the Department of Mental Health (DMH). ECT may be administered on either an inpatient or outpatient basis, depending on the Member's mental and medical status. Providers should follow DMH regulations that govern administration of this procedure. ECT may cause short or long-term memory impairment of past or current events. The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is most commonly performed at a schedule of three (3) times per week. Maintenance ECT is most commonly administered at one to three-week intervals. The decision to recommend the use of ECT derives from a risk/benefit analysis for Members. This analysis considers the diagnosis of the individual and the severity of the presenting illness, the individual's treatment history, the anticipated speed of action/efficacy of ECT, the medical risks, and anticipated adverse side effects. Providers must complete a workup including medical history, physical examination, and any indicated pre-anesthetic lab work to determine that there are not contra-indications to ECT and that there are no less intrusive alternatives to ECT before scheduling administration of ECT

COMPONENTS OF SERVICE:

The general criteria for ECT are the following:

- Major depression with or without psychosis that has not been responsive to adequate trials of medication or when medication is contraindicated
- Previous therapeutic response to ECT
- Severe depression with life-threatening behaviors (e.g., refusal to eat or drink, compulsive and impulsive suicide tendencies) when the latency of action of medication places the Member at added risk

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Pre-ECT Evaluation:

- At a minimum, the provider or facility ensures it has documented a minimal set of procedures to be undertaken for all individuals including:
    - Psychiatric history and examination to determine the indication for ECT, including previous response to ECT
    - A psychiatric diagnostic assessment that includes a DSM-5 diagnosis, inclusive of psychosocial and disability concerns
    - A full mental status assessment including, at a minimum, a Mini Mental Status Examination and associated score
    - Careful review of all past treatments
    - Documentation of current and previous medications including pharmacotherapy. The medication prescribed, dosage, duration of each trial, compliance, response, side effects, and response to augmentation strategies
    - A medical evaluation specifically focused on the safety of ECT including an updated history and physical examination to assess for cardiovascular, pulmonary, neurologic systems risk including any past concerns with risks for anesthesia
    - A dental examination
    - All of the above needs to be documented in the Members record

Administering ECT:

- The individual should be fasting overnight prior to treatment
- The ECT psychiatrist should determine the choice of electrode placement and be skilled in both unilateral and bilateral ECT. The utilization of either procedure should be based on an ongoing assessment of risk versus benefit to the individual
- Close monitoring is provided during and after treatment until the individual is fully recovered from anesthesia including a focus on assessing Members cognitive functioning
- During treatment, monitoring includes observation of seizure duration, airway obstruction, agitation, vital signs, and adverse effects. Additionally, any onset of new risk factors, or significant worsening of those present at pre-ECT, should be evaluated prior to the next treatment
- After treatment:
    - For ECT administered in an acute setting: individuals are monitored for at least 24 hours to assess for cognitive side effects, or prolonged or late seizures (tardive seizures) that may occur after the ECT session
    - A neurology consultation is obtained if recurrent or prolonged seizures occur
    - For ECT administered in an outpatient setting: individuals are clinically assessed prior to each ECT session and after each ECT session for any adverse effects that may occur during the recovery period
    - It is expected that ECT providers will refer to the American Psychiatric Association's (APA) guidelines for ECT
- ECT treatment is usually done in 6-12 sessions at a frequency of 2-3 times a week. ECT frequency may change when a positive response is obtained as determined by the ECT psychiatrist and the attending psychiatrist working in consultation

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Training Expectations:

It is the expectation of CCA that all contracted providers will offer ongoing staff training in order to best serve the diverse identities and experiences of the CCA Member population. Staff training should be inclusive of, but not limited to:

- Social determinants of health (SDOH)
- Trauma-informed behavioral health and medical care (including, but not limited to, ways in which the ACE study informs care delivery for Members, and trauma-specific treatment approaches)
- Best practices in delivering LGBTQIA+ inclusive and affirming— and, specifically, transgender inclusive and affirming— behavioral health and medical care
- Best practices in delivering culturally responsive, inclusive, and anti-racist behavioral health and medical care
- Best practices in health equity and inclusivity for Members of various racial, ethnic, and cultural backgrounds, as well as disabled Members, Members of various religious backgrounds, and Members with multiply marginalized identities
- Organizational strategies and resources for accessing interpreter services for Members who primarily communicate in languages other than English (including ASL)

Transgender Inclusive and Affirming Expectations:

It is the expectation of CCA that all contracted providers will provide inclusive and affirming care to our transgender/non-binary/gender diverse Members. This expectation is inclusive of, but not limited to:

- Consistently using the name and pronouns that the Member uses for themselves, even if this is not the name and/or pronoun set reflected in the Member's legal identification and/or CCA insurance card
- Making admission decisions without regard to the Member's gender identity
- Making determinations about access to any gender-based/gender separated service based on the gender with which the Member identifies, even if this is not the gender reflected in the Member's legal identification and/or CCA insurance card
- Ensuring that staff are regularly trained in best practices in delivering LGBTQIA+ inclusive and affirming— and, specifically, transgender inclusive and affirming— behavioral health and medical care

Trauma-Informed Care Expectations:

It is the expectation of CCA that all contracted providers will provide care to our Members that is fundamentally trauma informed. Trauma-informed care is inclusive of, but not limited to:

- Providing staff with ongoing training in trauma-informed behavioral health and medical care (including, but not limited to, ways in which the ACE study informs care delivery for Members, and trauma-specific treatment approaches)
- Providing comprehensive trauma screening as part of the standard evaluative process, in order to avoid potentially traumatic re-screening
- Integrating knowledge of trauma, and trauma responsiveness, into the creation and implementation of policies and procedures
- Including the Member's voice, involvement, and feedback in treatment planning—including offering

harm reduction strategies in all aspects of treatment
- Seeking to avoid re-traumatization for Members receiving care by creating a safe treatment environment
- Offering trauma-specific treatment interventions and approaches

STAFFING REQUIREMENTS:
- The facility will have a director who holds an advanced degree from an accredited college/university or discipline appropriate to the care and treatment of the mental illness
- The facility will have a board-certified physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in Psychiatry to perform ECT
- Facility holds a Class VIII License issued by DMH to perform this service and meets all staffing requirements required in CMR 104 under that license class
- The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the service-specific performance specifications, and the credentialing criteria
- In addition to the above, the ECT treatment requires a multi-disciplinary team that includes:
  - Anesthetist
  - Nursing staff with a specialty in psychiatric nursing
  - Consultant internist, neurologist, radiologist, and other specialists as appropriate, all who have been trained in working with Members diagnosed with mental health and psychiatric diagnosis

ASSESSMENT, TREATMENT PLANNING, DOCUMENTATION:
- The initial assessment between the physician and the Member includes all of elements of the Pre- ECT Evaluation listed above as well as all the elements of an initial psychiatric evaluation and a medical evaluation with a focus on major areas of risk including history of seizures or other neurological conditions
- The provider ensures there is documentation in the Member's health record with reference to ECT being used for treating target symptoms in an individual with one of the following conditions:
  - Severe depressive illness, a prolonged or severe manic episode
  - The affective components of schizophrenia and related psychotic disorders, catatonia, or neuro malignant syndrome (NMS)
- ECT is used only to achieve rapid and short-term improvement of an individual's severe symptoms after an adequate trial of other treatment options has proven ineffective
- The ECT provider and program will develop a preliminary individualized treatment plan with expected length and number of treatments prior to the initiation of treatment. By the 3rd treatment, an updated treatment plan will be written, including projected length and number of treatments to be delivered. This information is updated in the Members record

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- The provider ensures that the Member and the Member's legal guardian and the psychiatrist are in agreement that administration of ECT is appropriate based on a clear understanding of the risks and benefits of ECT
- The provider documents the Members informed consent. If the Member cannot give consent, this is documented in the Members record. Informed consent needs to be presented and reviewed in a culturally sensitive manner and in the Members language of choice
- With consent, the Members family and or other natural supports are included in the initial assessment and informed consent process
- All treatment outcomes, and will be documented in the Member's record
- All data regarding the seizure activity, anesthesia, number of treatments, response to treatments and other Regulations set forth by DMH regulations shall be recorded in the Member's record
- The program makes all reasonable efforts to assure that Members have access to supportive staff during the time immediately following a treatment
- **The provider obtains a prior authorization from CCA for ECT treatment by completing the Standardized Prior Authorization RequestForm and faxing the form to 855-341-0720**
- Best practices for care include collaboration with Commonwealth Care Alliance Care Team. With the approval from the Member and appropriate release of information, Providers are expected to contact **the CCA Care Team using CCA's Provider Services Line 866-420-9332 (option #4)** to alert the Members Care Team that the Member is receiving services and to discuss any services that might help support the Member for seamless continuity of Care

DISCHARGE AND COLLABORATION WITH COMMUNITY BASED PROVIDERS & SERVICES:

- The ECT treatment team collaborates with the Member's outpatient providers in the development of treatment and discharge plans
- The discharge Planning includes Member's identified psychosocial concerns housing, finances, healthcare, transportation, familial, occupational, educational and social supports
- The treatment team documents all of the discharge-related activities that have occurred while the Member is in the facility, including Member participation in its development in the medical record
- Upon discharge, discharge paperwork and agency referrals are given to the Member, and when appropriate, the Member's family or guardian and includes appointments, medication information and emergency/crises information. The discharge plan is documented in the Members record
- For Members discharged on medications, at least one psychiatric medication monitoring appointment is scheduled no more than 14 days after discharge

QUALITY MANAGEMENT:

- The facility will develop and maintain a quality management plan which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides

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- The facility utilizes a continuous quality improvement process and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including their families
- Clinical outcomes data must be made available to Commonwealth Care Alliance (CCA) upon request, and must be consistent with CCA's performance standard for ECT
- Providers will comply with all applicable laws and regulations including but not limited to any and all applicable Medicare and/or Medicaid laws, regulations and instructions of CMS and/or EOHHS relating to addressing and reporting Serious Reportable Events (SREs). Network providers will comply with all requirements contained in their contract with CCA including any corrective actions required by CCA or applicable regulatory agencies. A more complete list of SRE's can be found in Section 11 of CCA's Provider Manual.

REIMBURSEMENT:
Please refer to CCA's Covered Services and Prior Authorization PDF in the Provider Manual Link: Here

PAYMENT POLICIES:
Please refer to CCA's Payment Policies
Link: Here

BILLING PROCEDURES:
Please refer to SECTION 6: Claims and Billing Procedures section in CCA's Provider Manual.
Link: Here

Insurance eligibility must be confirmed on a regular and frequent basis. Eligibility may be confirmed by utilizing the current MassHealth Provider Online Service Center on the Eligibility Verification System (EVS).

APPROVALS:

CCA Business Process Owner	
Julie Fine	VP, Clinical Strategy & Implementation •
Print Name	**Print Title**
Julie D. Fine, LICSW	4/12/2023
Signature	**Date**

CCA Senior Clinical/Operational Lead	
Print Name	**Print Title**

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Signature	**Date**

CCA CMO or Designee	
Nazlim Hagmann, MD	Associate Chief Medical Officer
Print Name	**Print Title**
Nazlim Hagmann	4/12/2023
Signature	**Date**