FHC First Healthcare Mente Sana. Vida Plena.	Effective date: 01/01/2024 Review date: 11/05/2025	Policy No.: URD042 Page 1 of 7
Department: Utilization Review	Applies to: ☒ Medicare Advantage ☐ Commercial Accounts ☒ Medicaid	
Policy name: Electroconvulsive Therapy (ECT) Clinical Criteria		
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PURPOSE

This policy outlines the clinical and administrative standards for the use of Electroconvulsive Therapy (ECT) within the organization. It incorporates the latest guidelines from the American Psychiatric Association (APA), Change Healthcare InterQual® and evidenced based literature.
To establish the Organization's position regarding timely response to service requests for Electroconvulsive Therapy (ECT) services.

POLICY

The organization conducts clinical reviews of medical necessity for both initial and ongoing ECT services. In the absence of CMS national or local coverage determinations, the annually updated InterQual® Behavioral Health Criteria is used to guide decisions.

DEFINITIONS

1. Electroconvulsive Therapy (ECT) – A procedure using electrical stimulation to induce a controlled seizure under general anesthesia, primarily for severe depression, bipolar disorder, psychosis, catatonia, and neuroleptic malignant syndrome.
2. InterQual® Behavioral Health Criteria - Review Manager (Change Healthcare) – a clinical decision support product purchased by FHC, with criteria set that assists clinicians to triage patients to the most appropriate level of care and validate the current level of care. Criteria are based on patient-specific pertinent psychiatric, and substance use clinical findings.
3. Law 408 "Ley de Salud Mental de Puerto Rico" – the Law 408 is the current Puerto Rico law that rules Mental Health Services in Puerto Rico. This law created in 2004 with amendments, has the goal and purpose of establishing the needs of prevention, treatment, recovery and rehabilitation in mental health, create "Letters of rights" for adults and minors receiving mental health services, standardize procedures related to these rights, and establish the basic principles of levels of care in the provision of mental health services.
4. Pre-ECT evaluations – Includes psychiatric and medical history, physical exam, anesthesia clearance, and additional tests as needed.
   a. Depending on the findings, additional evaluations may be ordered for care risks for administering ECT or anesthesia. Other evaluations may include labs, EKG, imaging, or specialist consultation.
   b. There are no medical or psychiatric conditions that are absolute contraindications to ECT, but certain conditions may require special precautions, or a detailed risk-benefit analysis of ECT.

PROCEDURE

1. Diagnostic Criteria Summary Table

Diagnosis	Indications for ECT
Major Depression	Treatment resistance, suicidal ideation, psychotic features

Bipolar Disorder	Severe depressive or manic episodes
Schizophrenia	Catatonia, severe positive symptoms, non-response to traditional antipsychotic drug therapy
Catatonia	Non-response to benzodiazepines
Neuroleptic Malignant Syndrome	Medical emergencies requiring rapid intervention

2. Treatment Considerations and Expectations for Adults:
   a. The patient must have been referred by a psychiatrist.
   b. The psychiatrist with privileges to provide ECT will validate that the referred patient meets the diagnoses and conditions for which evidence has shown that the patient is likely to respond positively to ECT.
   c. The ECT procedure will be performed by a psychiatrist who participates in continuing medical education on ECT, and who maintains all certifications required by law and by the Board of Medical Licensure and Discipline.
   d. The provider has deemed the risk of administering ECT to be less than that of other equally effective treatments.
   e. There must be a medical evaluation that addresses any medical conditions that may increase the risks of ECT or anesthesia, as well as medical clearance from an anesthesia specialist to determine if the patient's condition requires special precautions.
   f. The totality of prescribed medications that the patient is using should be evaluated, and if the patient is using certain medications that could negatively impact the procedure, documentation should be included to justify the reason for continuing with them (cardiovascular, anticoagulants, hypoglycemics, antiasthmatics, gastrointestinal, lithium, benzodiazepines, anticonvulsants).
   g. All medical and psychiatric evaluations should consider the possibilities of relevant comorbid conditions.
   h. Patient and family education about risks and benefits of treatment is required.
   i. Informed consent as defined by Puerto Rico's Law 408 of 2000 and express written authorization is required.
   j. If this treatment is indicated for the adult, but who due to his condition cannot consent, and does not have a legally appointed guardian, it shall be necessary to hold a hearing for the Court to determine whether or not the treatment proceeds and issue an order to that effect.
   k. The adult who is being considered for electroconvulsive therapy treatment and his or her guardian, if any, shall be notified of such intention at least forty-eight (48) hours prior to the treatment.
   l. Any adult shall have the right to refuse such treatment at any time, including after having accepted such treatment.
   m. According to Law 408 of 2000, every entity providing mental health services, which offers the modality of electroconvulsive therapy, shall have a protocol that incorporates the standards accepted by the American Psychiatric Association (APA) and the entities that regulate the administration of such therapy.
   n. It shall be the responsibility of the mental health provider to keep abreast of scientific advances that may alter the procedures or administration of this treatment modality.

o. If the patient receiving ECT is undergoing acute in-hospital treatment, he or she may continue ECT treatment on an outpatient basis once stable and does not require a more restrictive level of care.
p. If a patient admitted to the hospital is a candidate for ECT, it needs to be contemplated from the onset of hospitalization. Any foreseeable delay in identifying ECT as part of the treatment plan, and this obviously delays the patient's recovery, could result in denials of hospital days.
q. A treatment plan needs to be formulated that includes estimated time and sessions for acute treatment, and whether continuity and maintenance are recommended. If continuity and/or maintenance treatment is recommended, a short and long-term plan needs to be developed, and this will be shared and discussed with the psychiatrist in charge of the member's outpatient follow-up.

3. Relative Contraindications
   a. While no absolute contraindications exist, patients with the following conditions are required to be subject to a more extensive evaluation of the risks and benefits of such treatment, including medical evaluation and clearance by subspecialists in the area.
      i. Recent myocardial infarction
      ii. Uncontrolled cardiac arrhythmias
      iii. Active intracranial lesion
      iv. Intracranial hypertension
      v. Cerebral aneurysms

4. Pharmacological Considerations
   a. Prior to establishing the diagnosis of treatment resistance, and recommending electroconvulsive therapy, clinicians must rule out causes of pseudo-resistance, such as:
      i. Non-adherence,
      ii. Suboptimal pharmacotherapy,
      iii. Suboptimal non-pharmacological treatments,
      iv. Misdiagnosis,
      v. Concurrence with other mental disorders such as personality disorders, substance use disorders or medical conditions,
      vi. Drug-drug interactions,
      vii. Ultra-rapid metabolizers of the p450 enzyme.
   b. Benzodiazepines
      i. They should be titrated and discontinued whenever possible during ECT because of their anticonvulsant properties, so they may increase seizure lintel, shorten seizure duration, and decrease seizure intensity by ECT. This could cause a decrease in the clinical effectiveness of ECT.
      ii. For patients who require continuation on benzodiazepines during ECT, it is reasonable to switch to short half-life medications, and to stop the evening dose prior to each ECT. Small doses of benzodiazepines may not be a problem for the procedure.
      iii. Another alternative for patients who need to continue the use of benzodiazepines is to use Flumazenil prior to induction with anesthesia.
   c. Anticonvulsants

i. Anticonvulsants can interfere with the effectiveness of ECT, similar to benzodiazepines. When anticonvulsants are used for mood stabilization, they should generally be titrated out and discontinued prior to ECT. For patients with epilepsy, anticonvulsant use should continue, but modifications should be considered to reduce the risk of affecting ECT results.

d. Lithium
   i. The use of lithium in patients receiving ECT does not have to be discontinued, as it does not affect the effectiveness of the seizure. If it should be kept in mind, lithium has the potential to increase the cognitive adverse effects of ECT and to prolong the effects of Succinylcholine.

Medical Necessity Criteria

1. Criteria for Initiating Acute Electroconvulsive Therapy (ECT) (Short Term)
   General Requirements:
   a. It will be the responsibility of the facility to know the details of the processes established by the plan for the management of its beneficiaries. It will also be the facility's responsibility to know the insured's eligibility and coverage to comply with basic elements of medical necessity according to the condition.
   b. Confirm the diagnosis for which he/she will be treated. Rule out organic conditions, substance disorder and personality disorder as determinants of your current mental condition.
   c. Complete the pre-ECT medical evaluation and have been cleared by the evaluating physician.
   d. Obtain informed consent from the patient or legal guardian as defined in Act 408 of 2004.
   e. Complete a short- and long-term treatment plan.
   f. For accounts requiring approval, the completed application must be submitted at least twenty-four (24) hours in advance to avoid delays.
   g. The criteria for ECT treatment are separate from the criteria for acute hospitalization. The need for ECT is not considered sufficient criteria to justify an acute psychiatric hospital stay. Administering ECT during an acute hospitalization, where the patient does not present criteria for hospitalization, will result in denial of days where there was a failure to demonstrate medical necessity.
   h. Requirements specific to the psychiatric condition:
      i. For Confirmed Unipolar Depression requires documentation showing evidence of severe symptoms of high intensity causing acute and severe impairment in functioning, such as persistent suicidal behavior, presence of medical sequelae due to lack of nutrition and hydration, severe and persistent self-harm in the absence of a personality disorder; and any of the following:
         - confirmed therapeutic failure prior to admission to a psychiatric facility of at least two treatments of two (2) different classes of antidepressants. Antidepressants must have been treated consistently for more than three (3) weeks at maximum tolerated doses
         - evidence of response to previous acute ECT for a clinical picture similar to the present.

ii. For confirmed Bipolar Depression requires documentation showing evidence of severe symptoms of high intensity causing acute and severe impairment in functioning, such as persistent suicidal behavior, presence of medical sequelae due to lack of nutrition and hydration, severe and persistent self-harm in the absence of a personality disorder; and any of these elements:
   - confirmed therapeutic failure prior to admission to a psychiatric facility of two (2) established antidepressant medications for Bipolar Depression (Lurasidone, Olanzapine, Fluoxetine combined, Quetiapine regular or extended release, Cariprazine, Lumateperone, Lamotrigine, Abilify, Brexpiprazole, Lithium). Each of the drugs must have been treated consistently at adequate doses and for an acceptable period according to the profile of each drug,
   - evidence of response to previous acute ECT for a clinical picture similar to the present one.

iii. For an episode of Mania (Bipolar or Schizoaffective) requires documentation showing evidence of severe symptoms of high intensity causing acute and severe impairment in functioning; and any of the following:
   - confirmed therapeutic failure prior to admission to a psychiatric facility of two (2) antipsychotic medications indicated for treatment of mania or mood stabilization, each of the medications must have been treated consistently at adequate doses and for an acceptable period of time according to each drug's profile or,
   - evidence of response to previous acute ECT for a clinical condition similar to the present one.

iv. For an episode of Psychosis in confirmed diagnoses of Schizophrenia, Schizoaffective, Schizophreniform or Postpartum Psychosis requires documentation showing evidence of severe symptoms of high intensity causing acute and severe impairment in functioning, and either of these elements:
   - confirmed therapeutic failure prior to admission to a psychiatric facility of two (2) antipsychotic medications, each of the medications must have been treated consistently for a period of at least six (6) weeks at the maximum effective dose or,
   - evidence of response to previous acute ECT for a clinical condition similar to the present.

v. For treating psychotic conditions of Schizophrenia and Schizoaffective Disorder, documentation showing evidence of therapeutic failure with Clozapine is required.

vi. For other conditions that may require acute treatment of ECT, evidence of persistent in-hospital suicidal behavior; catatonia; neuroleptic malignant syndrome is required.

2. Criteria for Continuing Acute Electroconvulsive Therapy (ECT) (Short Term)
   a. Applies to any additional authorization for acute treatment (outpatient or inpatient).
   b. Frequency of treatment must be dictated by the severity of symptoms.
   c. Documentation showing evidence that the patient's symptoms of which the ECT was indicated has decreased or remitted, including the goals of subsequent sessions of therapies.
   d. Progress must be assessed for each ECT session administered and the treatment plan must be reviewed.

e. FHC should be contacted at least twenty-four (24) hours in advance for additional sessions beyond those already authorized and mediate a discussion with a consulting psychiatrist.
f. If there is no clinical improvement after six (6) sessions, the potential benefits of additional ECT sessions should be reevaluated and reported.
g. If the patient achieves recovery in fewer sessions than authorized, this must be communicated to FHC.
h. The criteria for ECT treatment are independent of the criteria for acute hospitalization. The need for ECT is not considered sufficient criteria to justify an acute psychiatric hospital stay. Administering ECT during an acute hospitalization, where the patient does not present criteria for hospitalization, will result in denial of days where there was a failure to demonstrate medical necessity.

3. Criteria for Continuity Electroconvulsive Therapy (ECT)
Outpatient treatment for up to six (6) months following acute ECT, documentation must show evidence that the patient's symptoms of which the ECT was indicated has decreased or remitted, including the goals of subsequent sessions of therapies..
   a. Submit the appropriate request and clinical documentation evidencing the medical criteria for service.
   b. Documentation showing evidence that patient is at risk of relapse if not treated.
   c. The purpose is to prevent relapse of mood altering or psychotic episodes that triggered acute ECT treatment initially.
   d. Medical and psychiatric evaluations are required prior to each treatment.
   e. The frequency of sessions will be the minimum necessary to sustain remission.
   f. The need for continuation of ECT must be reevaluated monthly.
   g. The treatment plan will be updated monthly and discussed with the outpatient psychiatrist.
   h. Discharge should be contemplated at each reassessment of the plan.
   i. Informed consent should be obtained at least with each update of the treatment plan.
   j. If the patient achieves stabilization in fewer sessions than authorized, this must be communicated to FHC.

4. Criteria for Maintenance Electroconvulsive Therapy (ECT)
Outpatient treatment of more than six (6) months, documentation must show evidence that the patient's symptoms of which the ECT was indicated has decreased or remitted, including the goals of subsequent sessions of therapies
   a. Submit the appropriate request and clinical documentation evidencing the medical criteria for service.
   b. Documentation showing evidence that the patient is at risk of recurrence if not treated.
   c. The purpose is to prevent recurrence of mood altering or psychotic episodes in patients who have achieved recovery from an acute episode by ECT.
   d. Requires medical and psychiatric evaluations prior to each treatment.

ATTACHMENTS
N/A

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POLICY AND PROCEDURE REVISIONS

Date	Changes	Reasons
11/12/2024	Format	Annual Review
10/20/2025	Added procedures 1 and 3 Revised wording for better clarity Updated references	Annual Review
11/05/2025	Format	Annual Review