

Electroconvulsive Therapy (ECT)

Guideline Number: BHCDG122015

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Product:

2001 Generic UnitedHealthcare COC/SPD

2007 Generic UnitedHealthcare COC/SPD

2009 Generic UnitedHealthcare COC/SPD

2011 Generic UnitedHealthcare COC/SPD

May also be applicable to other health plans and products

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Related Coverage Determination Guidelines:

Treatment Depressive Disorders

Related Medical Policies:

Level of Care Guidelines

INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California ("Optum-CA")). When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently, or there is otherwise a conflict between this document and the COC/SPD, the enrollee's specific benefit document supersedes these guidelines.

All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.

Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.

While this Coverage Determination Guideline does reflect Optum's understanding of current best practices in care, it does not constitute medical advice.

Key Points

- Electroconvulsive therapy (ECT) is a treatment technique typically administered by a psychiatrist privileged to perform ECT and an anesthesiologist delivered in inpatient or outpatient settings that provokes a therapeutic response by applying an electrical current to the brain to induce a controlled seizure. The course of Electroconvulsive Therapy is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.
- ECT may be provided on an outpatient basis or during an inpatient stay.
- The initial, acute phase of ECT (aka, the index course) may be followed by continuation and maintenance phases of treatment when clinically indicated.
- The most common principal diagnostic indicators for ECT are:
 - Major Depression
 - Bipolar Disorder
 - Schizophrenia Spectrum and other Psychotic Disorders
- Benefits are available for covered services that are not otherwise limited or excluded.
- Pre-notification is required for ECT administration in any setting.
- Services should be consistent with evidence-based interventions and clinical best practices as described in Part II, and should be of sufficient intensity to address the member's needs (UnitedHealthcare Certificate of Coverage, 2007, 2009 & 2011).

PART I: BENEFITS

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

Benefits

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

Covered Services

Covered Health Service(s) – 2001

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions.

Covered Health Service(s) – 2007, 2009 and 2011

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

Pre-Service Notification

Outpatient ECT and inpatient admissions require pre-service notification. Notification of scheduled treatment must occur at least five (5) business days before admission. Notification of unscheduled treatment (including Emergency admissions) should occur as soon as is reasonably possible. In the event that Optum is not notified of outpatient ECT or an inpatient admission, benefits may be reduced. Check the member's specific benefit plan document for the applicable penalty and allowance of a grace period before applying a penalty for failure to notify Optum as required.

Limitations and Exclusions

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee's benefit document, or is otherwise defined differently, it is the terms of the enrollee's benefit document that prevails.

Inconsistent or Inappropriate Services or Supplies – 2001, 2007, 2009 & 2011

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Additional Information

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all-inclusive list):

- Services that deviate from the indications for coverage summarized in this document.

PART II : COVERAGE CRITERIA

1. Admission Criteria

1.1. The member is eligible for benefits.

AND

1.2. The member's condition and proposed services are covered by the benefit plan.

AND

1.3. Services are within the scope of the provider's professional training and licensure.

AND

1.4. The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission).

1.4.1. Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

AND

1.5. The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission) require the intensity of services provided in the proposed level of care.

AND

1.6. Co-occurring behavioral health and medical conditions can be safely managed.

AND

1.7. Services are:

1.7.1. Consistent with generally accepted standards of clinical practice;

1.7.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.3. Consistent with Optum's best practice guidelines;

- 1.7.4. Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

- 1.8. There is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time.
 - 1.8.1. Improvement of the member's condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.
 - 1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency and wellbeing.

AND

- 1.9. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.

AND

- 1.10. The member is diagnosed with any of the following conditions:
 - 1.10.1. Major Depressive Disorder
 - 1.10.2. Bipolar Disorder
 - 1.10.3. Schizophrenia Spectrum and Other Psychotic Disorders

AND

- 1.11. The "why now" factors leading to admission, and/or the member's history of response to treatment suggest that any of the following indications are present:

ECT As a Primary Treatment

- 1.11.1. There is a need for a rapid, definitive response due to the severity of a behavioral health or medical condition.
- 1.11.2. The risks of other treatments outweigh the risk of ECT.
- 1.11.3. There is a history of poor response to medications or good response to ECT.
- 1.11.4. The member prefers ECT, consents to ECT and is capable, with the assistance of others, of complying with the treatment plan.

ECT As a Secondary Treatment

- 1.11.5. The member's signs and symptoms have not responded to at least one adequate medication trial.
- 1.11.6. ECT is less likely to result in intolerance or adverse side effects.
- 1.11.7. The member's psychiatric or medical condition has deteriorated to the extent that a rapid, definitive response to treatment is needed.

AND

- 1.12. The "why now" factors leading to admission, and/or the member's history of response to treatment suggest that the following medical contraindications do not preclude treatment:
 - 1.12.1. An unstable or severe cardiovascular condition;
 - 1.12.2. An aneurysm or vascular malformation that might be susceptible to rupture with increased blood pressure;
 - 1.12.3. Increased intracranial blood pressure such as may result from a brain tumor or lesion;
 - 1.12.4. A recent cerebral infarction;
 - 1.12.5. Pulmonary conditions such as COPD, asthma, or pneumonia.

AND

Inpatient ECT

- 1.13. The "why now" factors leading to admission cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive setting due to acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors. Examples include:
 - 1.13.1. The member's medical status rates an American Society of Anesthesiologists (ASA) score of 4 or 5
 - 1.13.2. Acute impairment of behavior or cognition interferes with activities of daily living to the extent that the welfare of the member or others is endangered.
 - 1.13.3. Psychosocial and environmental problems threaten the member's safety or undermine engagement in a less intensive level of care.

OR

- 1.14. The "why now" factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation cannot be addressed, and the member must be admitted to Inpatient.

OR

Outpatient ECT

- 1.15. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

- 1.16. The “why now” factors leading to admission can be safely, efficiently, and effectively assessed and/or treated in an outpatient setting.

Examples include:

- 1.16.1. The member’s medical status rates an American Society of Anesthesiologists (ASA) score of 1-3.
- 1.16.2. The signs and symptoms of a behavioral health condition do not undermine the member’s capacity to participate in outpatient ECT.

- 1.17. The member is willing and able to comply with the requirements of outpatient ECT.

2. Continued Service Criteria

- 2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active” services must be:

- 2.1.1. Supervised and evaluated by the admitting provider;
- 2.1.2. Provided under an individualized treatment plan that is focused on addressing the “why now” factors, and makes use of clinical best practices;
- 2.1.3. Reasonably expected to improve the member’s presenting problems within a reasonable period of time.

AND

- 2.2. The “why now” factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

- 2.3. Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

AND

- 2.4. The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated.

AND

Acute Phase

- 2.5. For inpatient ECT, treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - 2.5.1. Non-health-related services, such as assistance with Activities of Daily Living (e.g., feeding, dressing, bathing, transferring, and ambulating).
 - 2.5.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
 - 2.5.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Continuation Phase

- 2.6. The “why now” factors leading to admission, and /or the member’s history of response to treatment suggest that continuation of ECT is indicated. Examples include:
 - 2.6.1. Pharmacotherapy alone has not been effective.
 - 2.6.2. Pharmacotherapy cannot be safely administered.

Maintenance Phase

- 2.7. The “why now” factors leading to admission, and/or the member’s history of response to treatment suggest that continuation of ECT is indicated. Examples include:
 - 2.7.1. The member’s signs and symptoms have returned during attempts to stop or taper off continuation treatment.
 - 2.7.2. The member has completed continuation treatment, but the history of response to treatment indicates that recurrence is likely.

3. Discharge Criteria

- 3.1. The continued stay criteria are no longer met. Examples include:
 - 3.1.1. The “why now” factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.

- 3.1.2. The “why now” factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
- 3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
- 3.1.4. The member requires medical-surgical treatment.
- 3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.

PART III: BEST PRACTICES

1. The Initial Evaluation:

- 1.1. Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services (i.e., the “why now” factors).
- 1.2. Focuses on the member’s specific needs.
- 1.3. Identifies the member’s goals and expectations.
- 1.4. Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.
- 1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:
 - 1.5.1. The member’s chief complaint;
 - 1.5.2. The history of the presenting illness;
 - 1.5.3. The “why now” factors leading to the request for service;
 - 1.5.4. The member’s mental status;
 - 1.5.5. The member’s current level of functioning;
 - 1.5.6. Urgent needs including those related to the risk of harm to self, others, or property;
 - 1.5.7. The member’s use of alcohol, tobacco, or drugs;
 - 1.5.8. Co-occurring behavioral health and physical conditions;
 - 1.5.9. The history of behavioral health services;
 - 1.5.10. The history of trauma;
 - 1.5.11. The member’s medical history and current physical health status;
 - 1.5.12. The member’s developmental history;
 - 1.5.13. Pertinent current and historical life information including the member’s:

- 1.5.13.1. Age;
 - 1.5.13.2. Gender, sexual orientation;
 - 1.5.13.3. Culture;
 - 1.5.13.4. Spiritual beliefs;
 - 1.5.13.5. Educational history;
 - 1.5.13.6. Employment history;
 - 1.5.13.7. Living situation;
 - 1.5.13.8. Legal involvement;
 - 1.5.13.9. Family history;
 - 1.5.13.10. Relationships with family and other natural resources;
 - 1.5.14. The member's strengths;
 - 1.5.15. Barriers to care;
 - 1.5.16. The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
 - 1.5.17. The member's broader recovery, resiliency and wellbeing goals.
- 1.6. The provider uses the findings of the evaluation to assign a DSM/ICD diagnosis.

2. Pre-ECT Evaluation

- 2.1. A psychiatrist privileged to administer ECT organizes a treatment team comprised of at least the following:
 - 2.1.1. An anesthesiologist;
 - 2.1.2. A treatment nurse or assistant;
 - 2.1.3. A recovery nurse.
- 2.2. A psychiatrist privileged to administer ECT ensures that an evaluation is completed prior to beginning treatment. Documentation of the evaluation includes results of the following:
 - 2.2.1. The psychiatric history and examination including an assessment of the effects or prior ECT, to determine if ECT is indicated and to establish baseline psychiatric and cognitive status to serve as reference points for evaluating the effect of treatment.
 - 2.2.2. A medical evaluation to determine the member's current medical status and to identify potential risk factors.

- 2.2.3. An evaluation of indications for ECT and potential risks to determine if further evaluation is needed, and to inform the treatment plan. Examples of circumstances requiring further evaluation include:
 - 2.2.3.1. ECT is being considered for a child.
 - 2.2.3.1.1. Concurrence with the recommendation to treat is provided by 2 consultants experienced in the treatment of children.
 - 2.2.3.2. ECT is being considered for an adolescent.
 - 2.2.3.2.1. Concurrence is provided by 1 consultant.
 - 2.2.3.3. ECT is being considered for a pregnant woman.
 - 2.2.3.3.1. Consultation from an obstetrician is sought.
- 2.2.4. An anesthetic evaluation to determine the plan for administering anesthesia as well as recommendations for ongoing medications.
- 2.3. Prior to initiating a course of treatment, the psychiatrist ensures that the member is provided with information about their condition, ECT, and treatment alternatives. Following this, the psychiatrist obtains the member's consent.
- 2.4. Prior to initiating a course of treatment, the psychiatrist considers decreasing or withholding medications that may interfere with ECT or cause adverse effects. Examples include:
 - 2.4.1. Theophylline;
 - 2.4.2. Lithium;
 - 2.4.3. Benzodiazepines;
 - 2.4.4. Anticonvulsant medications.
- 2.5. Prior to initiating a course of treatment, the psychiatrist considers continuing medications that may augment ECT, or otherwise do not need to be withheld. Examples include:
 - 2.5.1. Antidepressants;
 - 2.5.2. Antipsychotics;
 - 2.5.3. Medications used to treat co-occurring medical conditions such as:
 - 2.5.3.1. Antihypertensive and antianginal medications;
 - 2.5.3.2. Anticonvulsants for members who have epilepsy;
 - 2.5.3.3. Asthma medications.

- 2.6. Choice of right unilateral versus bilateral electrode placement is driven by the risk of cognitive side effects and the potential therapeutic benefit. Evidence supporting the efficacy of right unilateral placement is strongest with Major Depressive Disorder.
 - 2.6.1. Decisions about electrode placement should be made in tandem with decisions about stimulus intensity.
- 2.7. Stimulus intensity is determined by three methods:
 - 2.7.1. Empirical titration;
 - 2.7.2. Formula-based procedures;
 - 2.7.3. Administration of a fixed stimulus intensity.

3. Treatment Planning

- 3.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses:
 - 3.1.1. The short- and long-term goals of treatment;
 - 3.1.2. The type, amount, frequency and duration of treatment;
 - 3.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;
 - 3.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;
 - 3.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.
- 3.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.
 - 3.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- 3.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.

- 3.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- 3.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.
 - 3.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
 - 3.5.2. When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.
- 3.6. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

4. Treatment Protocol

- 4.1. Acute phase ECT is typically delivered 3 times per week on non-consecutive days, and lasts until the member’s signs and symptoms remit, their response to treatment plateaus, or the member develops adverse effects. While there isn’t a standard number of sessions remission during the acute phase is typically achieved in up to 12 sessions.
- 4.2. Longer intervals of treatment are used during the continuation phase. Weekly treatment extending out to monthly is common. The continuation phase lasts up to 6 months past the onset of remission during the acute phase.
- 4.3. Maintenance ECT is administered frequently enough to sustain remission, usually at 1-3 week intervals. The duration of maintenance ECT is driven by the risk and benefit of continued treatment taking into account factors such as the member’s history of treatment, tolerance of treatment, the member’s preference, and their ability to comply with treatment.
- 4.4. Before each treatment the treatment team assesses whether:
 - 4.4.1. The member has followed pretreatment orders;
 - 4.4.2. There have been any significant changes in the member’s mental or medical status, signs and symptoms;
 - 4.4.3. There are any changes in the member’s medication regimen;

- 4.4.4. The member is experiencing adverse effects of treatment.
- 4.5. During treatment, the treatment team monitors the member's physiological status especially:
 - 4.5.1. Respiration;
 - 4.5.2. Cardiovascular functioning;
 - 4.5.3. Seizure duration.
- 4.6. After treatment the treatment team monitor's the member's recovery especially:
 - 4.6.1. Vital signs;
 - 4.6.2. Signs of delirium and agitation;
 - 4.6.3. Other adverse effects such as nausea or headache.

5. Discharge Planning

- 5.1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- 5.2. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:
 - 5.2.1. An appropriate discharge plan is in place prior to discharge;
 - 5.2.2. The discharge plan is designed to mitigate the risk that the "why now" factors which precipitated admission will reoccur;
 - 5.2.3. The member agrees with the discharge plan.
- 5.3. For members continuing treatment, the discharge plan includes:
 - 5.3.1. The discharge date;
 - 5.3.2. The post-discharge level of care, and the recommended forms and frequency of treatment;
 - 5.3.3. The names of the providers who will deliver treatment;
 - 5.3.4. The date of the first appointment including the date of the first medication management visit;
 - 5.3.5. The name, dose and frequency of each medication;
 - 5.3.6. A prescription sufficient to last until the first medication management visit is provided;
 - 5.3.7. An appointment for necessary lab tests is provided;
 - 5.3.8. Resources to assist the member with overcoming barriers to care such as lack of transportation of child care;
 - 5.3.9. Recommended self-help and community support services;

- 5.3.10. Information about what the member should do in the event of a crisis prior to the first appointment.
- 5.4. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.
- 5.5. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.
- 5.6. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
 - 5.6.1. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.
- 5.7. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.
- 5.8. For members not continuing treatment, the discharge plan includes:
 - 5.8.1. The discharge date;
 - 5.8.2. Recommended self-help and community support services;
 - 5.8.3. Information about what the member should do in the event of a crisis or to resume services.
 - 5.8.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.
- 5.9. Recurrence of signs and symptoms is controlled by gradually discontinuing ECT.
- 5.10. For members being discharged from inpatient, the first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur, but no later than 7 days from discharge.

ADDITIONAL RESOURCES

Clinical Protocols

Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline

Peer Review

Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis

Second Opinion Evaluations

Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance

Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee's clinical needs and goals, or if additional providers should be involved in delivering treatment.

DEFINITIONS

Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)

A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance use disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

Electroconvulsive Therapy (ECT) A treatment technique which provokes a therapeutic response by applying an electrical current to the brain.

Index Electroconvulsive Therapy The initial, acute phase of treatment using ECT.

Mental Illness Those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

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CODING

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

Limited to specific CPT and HCPCS codes?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
00104	Anesthesia for electroconvulsive therapy
90870	Electroconvulsive therapy (includes necessary monitoring)

Limited to specific diagnosis codes?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Limited to place of service (POS)?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Limited to specific provider type?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Limited to specific revenue codes?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
100-160	(Range describes various all-inclusive inpatient services)
900-919	(Range describes various unbundled behavioral health treatments/services)
1000-1005	(Range describes various sites that provide 24-hour services)

HISTORY

Revision Date	Name	Revision Notes
1/10/2013	L. Urban	Version 3-Final
10/2014	L. Urban	Version 4-Final
3/2015	L. Urban	Version 5-Final
3/2016	G. Niewenhous	Version 6-Final

The enrollee's specific benefit documents supersede these guidelines and are used to make coverage determinations. These Coverage Determination Guidelines are believed to be current as of the date noted.