ELECTROCONVULSIVE THERAPY
PSY301.013
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COVERAGE:

Electroconvulsive therapy (ECT) **may be eligible for coverage** for patients who meet all the following criteria:

- Patient is diagnosed with one of the following conditions:

  a. Major depression,
  b. Mania,
  c. Catatonia (a non-specific symptom that can occur in mood disorders, schizophrenia, cognitive disorders, and medical and neurological illnesses),
  d. Certain acute schizophrenic exacerbations (i.e., psychotic schizophrenia when affective symptomatology is present), **AND**

- Patient is at least 12 years of age; **AND**

- One or more of the following criteria is met:

  a. Patient is unresponsive to effective medications (adequate dose and duration) that are indicated for the patient's condition(e.g., antidepressants, antipsychotics, etc., as appropriate) or
  b. Patient is unable to tolerate effective medications or has a medical condition for which medication is contraindicated, or
  c. Patient has had favorable response to ECT in the past, or
  d. Patient is unable to safely wait until medication is effective , due to inanition (a condition characterized by marked weakness, extreme weight loss, and a decrease in metabolism resulting from prolonged and severe insufficiency of food), stupor, extreme agitation, high suicide or homicide risk, etc.

It is rare that a patient will receive more than 20 treatments in a treatment series.

Multiple monitored electroconvulsive therapy (MMECT) is considered **experimental or investigational** as its effectiveness has not been established.

DESCRIPTION:

ECT involves the intentional induction of generalized seizures to the anesthetized patient by administering electrical impulses to the brain for up to several seconds through scalp electrodes to produce a therapeutic effect. Treatments are typically administered by a psychiatrist and an anesthesiologist or anesthetist. ECT is usually administered in an inpatient setting, but can be administered in an outpatient facility with treatment and recovery rooms. ECT is usually administered two or three times a week, although ECT may be administered daily if tolerated.

In MMECT, a patient undergoes ECT in the usual manner, but before regaining consciousness, undergoes another session of ECT designed to elicit a second (or additional) seizure. The effectiveness of MMECT has not been established.

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RATIONALE:

The primary indication for ECT is **major depressive disorder**. ECT is usually considered when medications fail, cannot be tolerated, or may be dangerous, but it is a first line treatment for severely depressed patients who require a rapid response because of a high suicide or homicide risk, extreme agitation, inanition, or stupor. The average course of treatment for depression is 6 to 12 treatments, but some patients may require as many as 20.

ECT has been found to be more effective than Lithium in the treatment of **manic episodes**. ECT is generally reserved for those patients with bipolar disorder who are unable to safely wait until a medication becomes effective, who are not responsive to or unable to safely tolerate one of the effective medications, or who have had a good response to ECT in the past. The number of ECT treatments reported to be effective for mania has ranged from 8 to 20.

ECT is not effective for chronic schizophrenia. However, ECT may be effective for **psychotic schizophrenic exacerbations** when affective symptomatology is prominent, in catatonic schizophrenia, and when there is a history of a prior favorable response to ECT. Schizophrenia may require 17 or more ECT treatments.

A small number of ECT treatments often reverse **catatonia**, a nonspecific symptom that can occur in mood disorders, schizophrenia, cognitive disorders, and medical and neurological illnesses. Up to 12 treatments may be required in some patients.

There is very limited evidence that ECT is effective for **delirium**. In addition, there may be considerable risks with ECT in medically unstable patients. For these reasons, in 1999, the American Psychiatric Association (APA) concluded that ECT “has not been shown to be an effective treatment for general cases of delirium.” The APA recommends that ECT be “considered only rarely for patients with delirium due to specific etiologies such as neuroleptic malignant syndrome and should not be considered initially as a substitute for more conservative and conventional treatments.” ECT requests for delirium should be forwarded to the behavioral health medical director for review.

A few clinicians have reported the successful use of ECT in severe obsessive-compulsive disorder, anorexia nervosa, atypical psychosis, cycloid psychosis, epilepsy with alternating psychosis, and chronic pain disorder. Those disorders are not usually considered indications for ECT. Requests for ECT for these indications should be forwarded

to the behavioral health medical director for review.

ECT is not an effective treatment for dysthymic disorder, neuroses, dissociative disorders, hypochondriasis, conversion disorder, substance-related disorders and personality disorders.

Relative contraindications to ECT include space-occupying lesions of the brain, high intracranial pressure, intracerebral bleeding, recent myocardial infarction, retinal detachment, pheochromocytoma, high anesthesia risk, adolescents and children, or when a significant medical illness is present in which the risk outweighs the potential benefit.

The effectiveness of MMECT has not been established. The National Institutes of Health 1985 Consensus Development Conference Statement on ECT states that "Multiple monitored ECT (several seizures during a single treatment session) has not been demonstrated to be sufficiently effective to be recommended."

PRICING:

CPT codes 90870 and 90871 include the following monitoring procedures which can not be billed separately by either a psychiatrist or by an anesthesiologist administering the anesthetic:

- Electroencephalogram (EEG) monitoring;
- Cardiac monitoring;
- Pulse oximetry.

REFERENCES:

- U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health. "Electroconvulsive Therapy." National Institutes of Health Consensus Development Conference Statement. Bethesda, MD: NIH (June 10-12, 1985).
- McClellan, J, Werry J, et al. "Practice Parameters for the assessment and treatment of children and adolescents with bipolar disorder." *Journal of the American Academy of Child and Adolescent Psychiatry* (1997 Oct) 36 (10 Suppl):157S-76S.
- "AACAP official action. Practice Parameters for the assessment and treatment of children and adolescents with bipolar disorder." *Journal of the American Academy of Child and Adolescent Psychiatry* (1997 Jan) 36(1):138-57.
- Ciapparelli A, Dell'Osso L, et al. "Electroconvulsive therapy in medication-nonresponsive patients with mixed mania and bipolar depression." *Journal of Clinical Psychiatry (2001 Jul)62(7);552-5.*

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- Department of Health and Human Services, Center for Medicare and Medicaid Services (CMS), January 10, 2003. Noncoverage of Multiple Electroconvulsive Therapy(MECT)

DISCLAIMER:

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, takes precedence over Medical Policy and must be considered first in determining coverage. The member's contract benefits in effect on the date that services are rendered must be used. Any benefits are subject to the payment of premiums for the date on which services are rendered. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.
HMO Blue Texas physicians who are contracted/affiliated with a capitated IPA/medical group must contact the IPA/medical group for information regarding HMO claims/reimbursement information and other general polices and procedures.