

Level of Care Guidelines: UnitedHealthcare Electroconvulsive Therapy

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INTRODUCTION

Level of Care Guidelines are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. 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 guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply.

This guideline is provided for informational purposes. It does not constitute medical advice.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

Prior Authorization and Pre-Service Notification

Outpatient electroconvulsive therapy (ECT) and inpatient admissions require prior authorization or pre-service notification, depending on the member-specific benefit plan. 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 United Healthcare 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 United Healthcare as required.

DESCRIPTION OF SERVICE

Electroconvulsive therapy (ECT) is a treatment device used for treating severe psychiatric illness by applying a brief intense electrical current to precise locations on the head to induce a seizure that lasts less than one

minute. ECT is delivered in inpatient or outpatient settings and administered by a skilled psychiatrist privileged to perform ECT along with an anesthesiologist, and a nurse or physician assistant. ECT has been extensively studied with the longest history of use (American Psychiatric Association [APA], 2019; National Institute of Mental Health [NIMH], 2016).

COVERAGE RATIONALE

ECT is medically necessary: to treat severe, treatment-resistant depression, and may also be useful in treating individuals with bipolar disorder and schizophrenia that have not responded to other treatments (APA, 2019; NIMH, 2016).

ECT is not medically necessary for any of the following:

- Multiple-seizure electroconvulsive therapy (MECT). The efficacy of ECT for these indications has not been verified by in well-designed controlled trials. In addition, studies have demonstrated an increased risk of adverse effects with multiple seizures (CMS NCD, 2003).
- Other diagnoses in the absence of major depressive disorder, bipolar disorder, or schizophrenia disorder, including, but not limited to any of the following:
 - Substance use disorders (APA, 2006);
 - Autism spectrum disorders (National Autism Center, 2015);
 - Obsessive-compulsive disorder (APA, 2007);
 - Posttraumatic stress disorder (APA, 2004; VA/DOD, 2017).

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with evidence-based clinical guidelines.

APPLICABLE CODES

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 imply that 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 clinical criteria may apply.

Procedure Codes	Description
00104	Anesthesia for electroconvulsive therapy
90870	Electroconvulsive therapy (includes necessary monitoring)

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APPENDIX

Additional resources considered in support of this document:

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