Outpatient Electroconvulsive Therapy

Table of Contents
- Policy: Commercial
- Coding Information
- Information Pertaining to All Policies
- Policy: Medicare
- Description
- References
- Authorization Information
- Policy History
- Endnotes

Policy Number: 319
BCBSA Reference Number: N/A
NCD/LCD: Local Coverage Determination (LCD): Psychiatry and Psychology Services (L33632)

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Outpatient ECT may be MEDICALLY NECESSARY when administered by a BCBSMA network-credentialed psychiatrist in a qualified acute care general hospital or contracted acute care psychiatric hospital, when ALL the following conditions are met:

- **Clinical Indications**: ECT has been found to be effective for major depression, bipolar depression and mania, and certain acute schizophrenic exacerbations. Most ECT is performed to treat depression. ECT is not typically a first-line treatment for depression, but exceptions include severe or psychotic subtypes or acute suicidality in major depression or severe geriatric depression. ECT may be appropriate for patients with recurrences who are prior ECT responders. ECT is also used for refractory depression, for patients with contraindications to medications. See below for Medicare HMO Blue and Medicare PPO Blue guidelines, AND

- **Informed consent** in writing from either the patient or legal guardian. The patient or legal guardian may withdraw consent at any time during treatment, AND

- **Outpatient status**: Patients receiving outpatient ECT should not require inpatient treatment for medical or psychiatric conditions, AND

- **Support**: Patients receiving outpatient ECT need to comply with pre- and post-treatments and have a responsible companion to provide transportation and assistance.

Children or adolescents (under 16) may receive ECT only when there is regulation and approval from the Department of Mental Health.

Note: Outpatient ECT is covered for up to 12 treatments. Documentation of medical necessity is required for treatments beyond the initial 12 sessions.
Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.

**Local Coverage Determination (LCD): Psychiatry and Psychology Services (L33632)**

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

**Prior Authorization Information**
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Commercial PPO and Indemnity</th>
<th>Medicare HMO Blue℠</th>
<th>Medicare PPO Blue℠</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**CPT Codes / HCPCS Codes / ICD Codes**
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90870</td>
<td>Electroconvulsive therapy (includes necessary monitoring)</td>
</tr>
</tbody>
</table>

**Description**

Electroconvulsive Therapy (ECT) is a procedure which involves deliberately sending electric currents through the brain to an anesthetized patient to trigger a brief seizure that changes the brain chemistry and alleviates symptoms of certain mental illnesses. 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.
Summary
ECT is effective for a narrow range of psychiatric disorders. It is effective for mood disorders both bipolar and unipolar. It can also be used to augment the treatment of schizoaffective disorder and schizophrenia. Most ECT is performed to treat depression and is not typically the first-line of treatment. However, ECT works more quickly than medications and should be considered as a first line treatment in life threatening catatonia or someone who is extremely suicidal. Research shows that ECT may be appropriate for patients with recurrences who were prior ECT responders and for refractory depression in patients with contraindications to medications or who are unwilling to take medications. When ECT is prescribed it should be part of a treatment plan overseen by a board certified psychiatrist in conjunction with other therapies when indicated.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/2015</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>1/1/2012</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
<tr>
<td>1/1/2011</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
<tr>
<td>2/2010</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
<tr>
<td>5/2009</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
<tr>
<td>2/2008</td>
<td>BCBSA National medical policy review. No changes to policy statements.</td>
</tr>
</tbody>
</table>

Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines
References
4. Guidelines on the Administration of ECT, Department of Mental Health, 104 CMR-58, 12/1/93, Commonwealth of Massachusetts. Policy prepared by the Subcommittee on Outpatient ECT, Medical Policy Committee, Mental Health Unit, Blue Cross Blue Shield of Massachusetts

Endnotes

1 Based on expert opinion