

*(Rescinds MCCMH Policy 3-04-180)*

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Chapter: **CLINICAL PRACTICE**  
Title: **ELECTROCONVULSIVE THERAPY (ECT)**

Prior Approval Date: 9/30/05  
Current Approval Date: 5/10/06

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Executive Director

Date

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**I. Abstract**

This policy establishes the standards and procedures for the use of electroconvulsive therapy (ECT) by MCCMH direct-operated and contract network providers administering or recommending administration of ECT to Macomb County Community Mental Health (MCCMH) consumers as authorized by the Board.

**II. Application**

This policy shall apply to all MCCMH direct-operated and contract network providers who may administer or recommend administration of ECT to MCCMH consumers.

**III. Policy**

It is the policy of the MCCMH Board that safe and appropriate standards and procedures be maintained in the use of ECT for MCCMH consumers by MCCMH direct-operated and contract network providers; ECT shall be administered only as an integral part of the consumer's documented current treatment /service plan, where indications for ECT are present, including but not limited to certain diagnosed conditions, failure of alternative treatments and medications to control symptomatology, medical history, and consumer preference. Additionally, it is the policy of the MCCMH Board that ECT be administered only after an ECT evaluation is made, informed consent secured, with approval of the MCCMH Medical Director, as outlined herein.

**IV. Definitions**

- A. Index ECT -- the initial series of ECT provided during the current treatment event either inpatient or outpatient. Such series may be completed during the treatment event or may be completed at another level of care.

- B. Outpatient Continuation ECT -- when a series of ECT's are initiated during the consumer's hospital stay, the consumer may be discharged prior to completion of the series. The remaining treatments in that ECT series are then continued on an outpatient basis. Treatments are for six (6) months and at intervals of one (1) week or longer.
- C. Outpatient Maintenance ECT -- a structured schedule of outpatient ECT treatments for the individual who has responded well to ECT in the past, and whose symptoms are not well-controlled by medication therapy after an appropriate trial period. Treatments are longer than six (6) months and at intervals of two (2) weeks or longer.

## V. Standards

- A. ECT is a special procedure that shall be administered only as an integral part of the consumer's documented current treatment/service plan.
- B. Indications for ECT may include but not limited to the following:
  - 1. Diagnosis/Symptom Complex:
    - a. Major Depressive Disorder
      - 1) Major Depression, single episode (296.2x)
      - 2) Major Depression, recurrent (296.3x)
      - 3) Bipolar I Disorder, depressed (296.5x)
      - 4) Bipolar I Disorder, mixed (296.6x)
      - 5) Bipolar I Disorder, not otherwise specified (296.80)
    - b. Mania
      - 1) Bipolar I Disorder, manic (296.0x)
      - 2) Bipolar I Disorder, mixed (296.6x)
      - 3) Bipolar I Disorder, not otherwise specified (296.80)
    - c. Schizophrenia and Other Functional Psychosis
      - 1) Psychotic schizophrenic exacerbation in the following situations:
        - a) Catatonic (295.2x)
        - b) When affective symptomatology is prominent
        - c) When there is a history of favorable response to ECT

- 2) Related psychotic disorders
  - a) Schizophreniform disorder (295.40)
  - b) Schizoaffective disorder (295.70)
2. Situations in which ECT may be used prior to trial of psychotropic medication include (but are not limited to):
  - a. Need for rapid, definitive response on either medical or psychiatric grounds
  - b. Risks of other treatments outweigh the risks of ECT
  - c. History of poor drug response and/or good ECT response for previous episodes of the illness
  - d. Patient preference
3. After a trial of an alternative treatment, referral for ECT should be based on at least one of the following:
  - a. Treatment failure
  - b. Adverse effects which are unavoidable and which are deemed less likely and/or less severe with ECT.
  - c. Deterioration of the consumer's condition such that there is a need for rapid, definitive response on either medical or psychiatric grounds.
- C. Contraindications may include but not be limited to:
  1. Space-occupying cerebral lesions or increased intra cranial pressure
  2. Recent MI with unstable cardiac function
  3. Recent CVA
  4. Unstable vascular aneurysm or malformation
  5. Retinal detachment
  6. Pheochromocytoma
  7. Anesthetic risk rated at American Society of Anesthesiologists (ASA) level 4 or 5
- D. All staff involved in the administration of ECT shall be properly credentialed and privileged. The hospital shall keep an updated list of physicians who have been credentialed and privileged to do ECT and such list will be available to MCCMH when requested.
- E. ECT evaluation shall include:
  1. A comprehensive psychiatric history and evaluation to determine indications for ECT; previous history of ECT and response, including adverse side effects.
  2. A medical evaluation, including a thorough history and physical exam, to identify medical risk factors and concurrent medical conditions causing or contributing to

the psychiatric disorder. Work-up shall include CBC and differential, electrolytes BUN and Creatinine, thyroid function test, SMA-12 and EKG.

3. An anesthesia evaluation to assess risk factors and need for modification of medication and/or anesthesia techniques.
  4. A second evaluation by another psychiatrist with ECT privileges who concurs with the initial recommendation.
  5. In case of pregnancy, OB-GYN clearance.
  6. In case of an adolescent consumer (less than 18 years of age), parent or guardian consent to the consumer's having electroconvulsive therapy. In addition, two (2) child and adolescent psychiatrists, neither of whom may be the treating psychiatrist, must have examined the consumer and documented in his/her medical record their concurrence with the decision to administer the procedure.
  7. Consultation with the consumer's outpatient team where applicable. The treating psychiatrist on the outpatient treatment team who provided services to the consumer prior to the current hospitalization and who will follow the consumer after hospitalization must agree that ECT is the best treatment for the consumer.
- F. A minor or an advocate designated by the minor shall be informed that he or she has a right to object to the procedure at least 72 hours (excluding Sundays or holidays) before the initiation of ETC. The objection shall be made either orally or in writing to the probate court. The ECT procedure shall not be initiated before a court hearing on the minor's or advocate's objection.
- G. If ECT is considered advisable for a consumer and an individual eligible to give consent for the procedure is not located after diligent effort, a probate court may, upon petition and after a hearing, consent to administration of the procedure in lieu of the individual eligible to give consent.
- H. An informed consent form shall be signed by the consumer / parent/ legal guardian / representative authorized to consent under a durable power of attorney or other advance directive and the physician. Informed consent shall be properly documented, with a description of ECT procedures including:
1. When, where, and by whom the treatments will be administered; the range of the number of treatment sessions recommended; and a brief overview of the ECT technique itself;
  2. A statement of why ECT is being recommended and by whom, including a consideration of reasonable treatment alternatives;

3. A statement that, as with any treatment modality, the therapeutic (or prophylactic) benefits associated with ECT may be transient;
  4. A statement as to the likelihood and severity of risks related to anesthesia, muscular relaxation and seizure induction, including: mortality, cardiac dysfunction, confusion, acute and persistent memory impairment, musculoskeletal and dental injuries, headaches, and muscle pain;
  5. An acknowledgment that, as with any other procedure involving general anesthesia, consent for ECT also implies consent to perform appropriate emergency interventions in the unlikely event this proves necessary during the time the consumer is not fully conscious;
  6. An acknowledgment that consent is voluntary and can be revoked at any time before or during the treatment course;
  7. A statement that the individual authorized to give consent is encouraged to ask questions at any time regarding ECT, and whom to contact for such questions;
  8. A description of any restrictions on consumer behavior that are likely to be necessary prior to, during, or following ETC.
- I. The decision to discontinue use of psychotropic agents is left to the discretion of the attending psychiatrist after assessing risk and benefits.
- J. For the purpose of coordinating delivery of ECT on an outpatient basis and to assure patient compliance and safety, the ECT facility provider will coordinate release of information to the receiving outpatient physician provider, to include:
1. Admit Notes/Psychiatric Evaluation;
  2. ECT Procedure Notes;
  3. Discharge Instructions including medications;
  4. Relevant medical, laboratory and medication information;
  5. Telephone numbers of ECT coordinator and ECT administering physician.
- K. Continuation ECT - Outpatient
1. Criteria for continuation ECT on an outpatient basis will include the following:
    - a. The consumer has completed an adequate number of ECT as an inpatient and demonstrated tolerance for the procedure with clinical improvement;

- b. The consumer no longer demonstrates a dangerousness to self, others or property that would warrant inpatient treatment;
  - c. The consumer has adequate support system resources such that the physician administering ECT might reasonably expect safety and compliance with outpatient ETC.
  - d. The consumer has been referred to an outpatient treatment team that agrees to monitor the consumer in outpatient ECT therapy; the treating psychiatrist on the outpatient treatment team concurs with continued ECT treatment for the consumer.
2. All consumer/family education, consultations, work-ups and consents will have been completed during the consumer's inpatient stay.
  3. Prior to discharge from the Inpatient Psychiatric program, the consumer and a responsible family member or friend will tour the Recovery Room and associated outpatient areas.
  4. The consumer and family member or friend will receive printed instructions regarding parking, scheduling, registration, waiting area, recovery, and discharge procedures for outpatient ECT treatments. Consumers receiving continuation ECT-outpatient must be accompanied by a responsible adult to and from each treatment.
  5. Education regarding outpatient ECT will be provided to the consumer and family (if available) and will be documented in the consumer's medical record.
  6. During the course of outpatient ECT, all relevant documentation regarding consents, consultations, work-up reports and ECT treatments to-date will be maintained in a secured and accessible area for the physician.

L. Maintenance ECT - Outpatient

1. Criteria for maintenance ECT - Outpatient will include the following:
  - a. The consumer's symptomatology currently is not being well-controlled with other treatment options;
  - b. The consumer does not meet admission criteria for inpatient psychiatric treatment;
  - c. The consumer has adequate support system resources such that the physician

might reasonably expect safety and compliance with ECT on an outpatient basis.

2. The work-up will be completed on an outpatient basis and will be documented in the consumer's medical record; this may include the following as deemed necessary by the ECT treating physician:
    - a. At a minimum, a history and physical exam and anesthesia consult;
    - b. EKG, CBC and Differential, Chemistry Profile, Urinalysis, Chest X-ray;
    - c. Spinal X-ray, EEG, and Brain CT Scan, when deemed necessary.
  3. Consumer and family education regarding ECT must be reflected in the consumer's record. The incorporation of relatives of the consumer during the process of obtaining informed consent for ECT is strongly encouraged. Consumers are entitled to refuse to view the ECT videotape if it may have a negative effect on the consumer's psychiatric condition. This refusal to view the videotape must be approved by the attending psychiatrist and the reasons documented in the consumer's medical record.
  4. Maintenance ECT will be provided on a schedule that is deemed to provide maximum benefit to the patient, not to exceed six (6) ECTs or six (6) months, whichever is less.
- M. Consumers discharged from inpatient with recommendation for outpatient continuation/maintenance ECT will be seen by the receiving outpatient physician within seven (7) days for psychiatric evaluation. The outpatient attending physician will coordinate/collaborate with the outpatient ECT administering physician as to the clinical appropriateness of ECT to the overall outpatient management of the consumer.
- N. Facility providers shall demonstrate compliance in the current and accepted community and/or national practice standards and/or guidelines in the administration and use of ETC.
- O. Quality assurance activities to review and monitor the use of ECT as medically necessary shall be documented. Upon request, the Facility provider shall provide MCCMH access to reports of QA activities related to MCCMH consumers.
- P. This policy shall be reviewed and updated annually, or sooner if necessary, by the appropriate MCCMH QA committee, Policy Management Division and Executive Staff of MCCMH, and must be approved by the MCCMH Executive Director.

## VI. Procedures

### A. MCCMH ECT Authorization

The Facility or Program provider requesting ECT shall forward the following within 72 hours (minimum) prior to ECT:

1. Completed MCCMH ECT Request Form, MCCMH #297 (revised) (Exhibit A);
2. The most current copy of the required certificate of need/continued stay review (CON/CSR) authorization;
3. Any necessary supporting medical records/documents.

NOTE: ECTs done without Prior Authorization will not be reimbursed by MCCMH.

The above documents will be faxed to:   MCCMH Access Manager  
  c/o Access Center, Fox Pointe Center  
  46360 Gratiot Avenue  
  Chesterfield Twp., MI 48051  
  Fax (586) 948-0213:

- B. In instances where the consumer must be transferred to a contracted hospital for ECT treatment, the referring Facility or Program shall request authorization from MCCMH Access Center by following the above procedures in A.1.
- C. The MCCMH Access Manager and the Utilization Management (UM) physician reviewer shall review submitted request forms and clinical records/documents. Clinical review will not occur unless all required information (oral and written) is available for determination of medical necessity.
- D. The MCCMH UM physician reviewer/MCCMH Access Manager shall notify the Facility Utilization Review Coordinator of disposition by phone and/or fax.
- E. All ECT dispositions/authorizations are made using the MCCMH ECT Authorization Form, MCCMH #298 (Exhibit B).

NOTE: All related/non-related Inpatient/Partial Hospitalization Program (PHP) Pre-Admission screening service authorization and continued stay review authorizations must occur on a prospective basis, as stipulated in the Inpatient/PIHP Contract Service Agreement with the MCCMH Board.

### F. Denial of ECT Request

1. If the MCCMH UM physician reviewer denies the attending physician's request for



ECT, the Rationale for Denial section of the ECT Authorization Form, MCCMH #298, shall state the rationale for the decision. The MCCMH UM physician reviewer shall ensure that the original form is mailed or faxed to the attending physician, while retaining a copy at the Access Center.

2. The attending physician shall ensure that the consumer is informed of his/her rights to appeal the denial, including: the informal resolution process of consumer/provider disagreements as provided in MCCMH MCO Policy 2-009 ; the local dispute resolution process as provided in MCCMH MCO Policy 9-170; the second opinion process as provided in MCCMH Policy 9-180; or the submission of a Recipient Rights Complaint, in accordance with MCCMH MCO Policy 9-510.

## **VII. References / Legal Authority**

- A. MCL 330.1716; MSA 14.800(716)
- B. MCL 330.1717; MSA 14.800(717)
- C. American Psychiatric Association's Special Task Force on ECT, 1990
- D. MCCMH MCO Policy 2-009, "Consumer/Provider Grievances"
- E. MCCMH MCO Policy 9-670; "Services for Recipients Affected By Physical Barriers"
- F. MCCMH MCO Policy 9-180; "Second Opinion Rights"
- G. MCCMH MCO Policy 9-510; "Recipient Rights Investigation"

## **VIII. Exhibits**

- A. ECT Request form, MCCMH #297 (revised)
- B. ECT Authorization form, MCCMH #298

**MACOMB COUNTY COMMUNITY MENTAL HEALTH  
ECT REQUEST FORM  
( PLEASE TYPE OR PRINT )**

Consumer Name \_\_\_\_\_ Adm Date \_\_\_\_\_ IP Facility Name \_\_\_\_\_  
 Guardian : \_\_\_\_\_ OP Program Name \_\_\_\_\_  
 MCCMH Case #: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Insurance:  Indigent  Caid  Care/Caid  Other \_\_\_\_\_

**I. DSM IV DIAGNOSIS**

	Code #	Code Description ( For Axis I, II, III only )
Axis I	_____	_____
Axis II	_____	_____
Axis III	_____	_____
Axis IV	_____	_____
Axis V	_____	_____

**II. (A). LEVEL OF ECT SERVICE REQUESTED:**       Initial Request       Continuation/Maintenance Request

(2011) \_\_\_\_ Acute Inpatient                      (2013) \_\_\_\_ Outpatient                      (2011) \_\_\_\_ Subacute

# of ECT's Year To Date \_\_\_\_\_

# of ECT's Previous Calendar Year \_\_\_\_\_

Number of ECT treatments being requested \_\_\_\_\_

Time frame ECT will be administered: From: \_\_\_\_\_ To: \_\_\_\_\_

Frequency of administration: \_\_\_\_\_  
 \_\_\_\_\_

**II. (B). RECOMMENDATION FOR ECT DOCUMENTED AND AGREEMENT FROM OUTPATIENT TREATING PSYCHIATRIST:**

Outpatient Psychiatrist Name \_\_\_\_\_ Date Contacted: \_\_\_\_\_

**III. (C) PLEASE IDENTIFY THE PLAN FOR FOLLOW UP AND/OR CONTINUED TREATMENT OF ECT PATIENTS AFTER DISCHARGE:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**III. (A). DESCRIBE PATIENT'S CURRENT CLINICAL STATUS AND RATIONALE FOR PROPOSED INITIAL ECT**

(include target symptoms):

a. Legal Status: Voluntary \_\_\_\_\_ Involuntary \_\_\_\_\_ Court Order Date & Type: \_\_\_\_\_

b. Level of depression: Severe \_\_\_\_\_ Moderate \_\_\_\_\_ Mild \_\_\_\_\_ As Evidenced By \_\_\_\_\_

c. Neurovegetative Symptoms: Sleep: \_\_\_\_\_ Appetite: \_\_\_\_\_ Weight: \_\_\_\_\_

d. Level of Suicidality: (Check) Ideation \_\_\_\_\_ Intent \_\_\_\_\_ Plan \_\_\_\_\_ Means \_\_\_\_\_ Attempt: Recent \_\_\_\_\_ Past \_\_\_\_\_

e. Psychotic Symptoms: (As Evidenced By) \_\_\_\_\_

f. Co-Morbid Substance Abuse: (Substance(s) used) \_\_\_\_\_

g. Significant Axis II Behaviors: \_\_\_\_\_

III. (B). PLEASE EXPLAIN RATIONALE FOR REQUEST OF ADDITIONAL ECT AND INDICATE HOW THE EFFECTIVENESS OF PREVIOUS ECT IS MEASURED (Continuation Request):

III. (C). PLEASE REPORT SYMPTOMS/PROBLEMS PRIOR TO ECT (pre-morbid state):

III. (D) PLEASE REPORT SYMPTOMS/PROBLEMS AFTER ECT (post-morbid state):

IV. LIST OF SIGNIFICANT MEDICAL PROBLEMS (Initial Request):

V. LIST OF ANY SUBSTANTIAL MEDICAL CONTRAINDICATIONS (Initial Request):

- |   |                    |  |                    |
|---|--------------------|--|--------------------|
| 1. Space occupying cerebral lesions:                                | Present__ Absent__ | 5. Retinal detachment:                   | Present__ Absent__ |
| 2. High intra-cranial pressure:                                     | Present__ Absent__ | 6. Pheochromocytoma:                     | Present__ Absent__ |
| 3. Recent myocardial infarction, with<br>unstable cardiac function: | Present__ Absent__ | 7. High anesthesia risk:                 | Present__ Absent__ |
| 4. Recent intracerebral hemorrhage:                                 | Present__ Absent__ | 8. Unstable aneurysm<br>or malformation: | Present__ Absent__ |

VI. LIST OF ALL **CURRENT** MEDICATIONS (Initial and Continuation Requests):

<u>Drug Name</u>	<u>Strength</u>	<u>Dosing Schedule</u>	<u>Date Initiated</u>
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VII. PAST TREATMENT HISTORY (Initial Request):

A. Psychiatric Hospitalizations (Initial Request):

<u>Date</u>	<u>Facility</u>	<u>Physician</u>	<u>ECT</u>	<u>Meds</u>	<u>Response</u>
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B. **Medication History** (Initial Request):

Medication	Highest Dosage	From/To	Response
1.			
2.			
3.			
4.			
5.			

VIII. **PLEASE NOTE:** The attending physician must enter adequate documentation in the medical record of the reasons for the procedure, that all reasonable treatment modalities have been carefully considered, and that the treatment is definitely indicated and is the most appropriate treatment available for this consumer at this time.

Form Completed By: \_\_\_\_\_  
(PRINT NAME) (SIGNATURE) (Date)

**I have reviewed this request form and attest to the content and accuracy of information provided:**

\_\_\_\_\_  
Attending Physician: \_\_\_\_\_  
(PRINT NAME) (SIGNATURE) (Date)

IX. **SECOND OPINION FOR ECT** (Initial Request):

1. Have you personally examined this patient?  Yes  No
2. Does this patient have the capacity to give written informed consent for treatment?  Yes  No
3. Is written informed consent documented in patient's treatment records?  Yes  No
4. Are there any absolute medical or psychiatric contraindications for ECT?  Yes  No
5. (a) Is patient pregnant? If Yes, see (b)  Yes  No  N/A  
(b) Is there an OB-GYN consult and clearance?  Yes  No
6. Has this patient been medically cleared?  Yes  No
7. I believe that Electroconvulsive treatment is the best treatment for this patient at this time and that other forms of treatment (especially psychiatric medications) would not be as effective.  Yes  No

Physician \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_  
(Second Opinion Signature)

Please return this completed request form to:

**MCCMH ACCESS CENTER**  
**ATTN: ACCOUNT CLERK / MEDICAL DIRECTOR**  
Fax No.: (586) 948-0213

cc: **MCCMH Medical Director**

**MACOMB COUNTY COMMUNITY MENTAL HEALTH  
ECT AUTHORIZATION FORM**

Requesting Facility \_\_\_\_\_

I. Consumer Name \_\_\_\_\_ ECT Tx Provider \_\_\_\_\_

Case No \_\_\_\_\_ SSN \_\_\_\_\_

DOB \_\_\_\_\_ Adm Date \_\_\_\_\_

Attending Physician \_\_\_\_\_, M. D. / D.O.

Second Opinion Physician \_\_\_\_\_, M. D. / D.O.

Date of Request \_\_\_\_\_

II. ECT Requested

\_\_\_\_ 2011 Inpatient      \_\_\_\_ 2013 Outpatient / Subacute / PHP (Circle One)

III. Approved       No. of ECT's \_\_\_\_\_      Denied

Rationale for Denial \_\_\_\_\_

Effective Dates:      From: \_\_\_\_\_      To: \_\_\_\_\_

Review Dates: \_\_\_\_\_

IV. Access Physician Reviewer: \_\_\_\_\_  
(PRINT Name)

\_\_\_\_\_  
Signature Date

cc: MCCMH Medical Director  
Facility UR Coordinator  
MCCMH Hospital Liaison  
Account Clerk, MCCMH Access Center