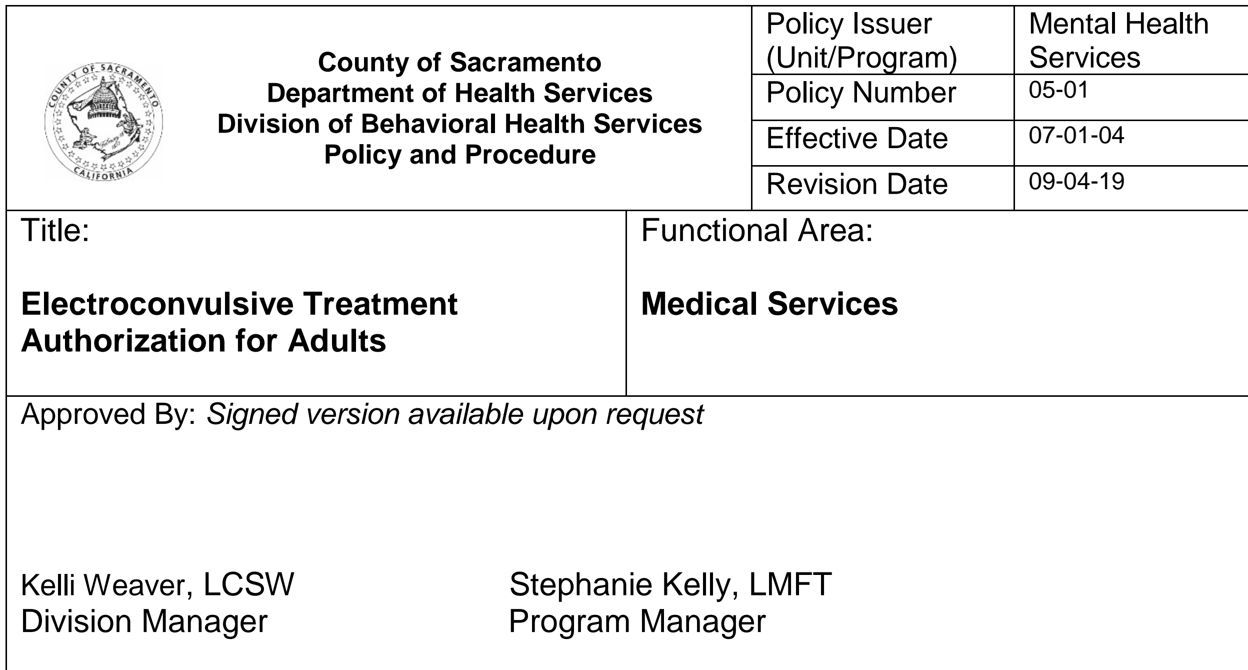

County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
	Policy Number	05-01
	Effective Date	07-01-04
	Revision Date	09-04-19

Title: **Electroconvulsive Treatment Authorization for Adults**	Functional Area: **Medical Services**
Approved By: *Signed version available upon request* Kelli Weaver, LCSW Division Manager	Stephanie Kelly, LMFT Program Manager

Background/Context:

Sacramento County Division of Behavioral Health Services reviews and considers all requests for Electroconvulsive Treatment (ECT) for eligible adults with serious mental illness. The Intensive Placement Team (IPT) is the designated Point of Access for this service.

Definitions:

- Avatar: Electronic Health Record System for Sacramento County Behavioral Health Services
- Intensive Placement Team: A clinical team responsible for evaluating referrals for high intensity outpatient services, subacute placement, and ECT. The IPT provides service authorizations for subacute placement, monitors the care of individuals receiving treatment within an authorized secured setting, promotes recovery efforts, collaborates with treatment teams, offers input in client treatment plans, attends utilization reviews, provides consultation when needed, and assists in discharge planning for clients stepping down from subacute to the community.

Purpose:

To establish a process for evaluating and authorizing services for current members of the Sacramento County Mental Health Plan (MHP) to receive ECT treatment in an ethical manner, when all other interventions have been exhausted.

Details:

A. Initial ECT Authorization Requests

1. The client's clinical treatment team completes the following and faxes to the IPT, using the fax number indicated on the Request for ECT referral form (see Attachment A):
   a. Request for ECT referral form (see Attachment A)
   b. ECT Informed Consent Form (See Attachment B) or court documentation indicating court authorized involuntary treatment.
   c. Supporting clinical documentation in recommendation of ECT, including current diagnoses, other treatment modalities attempted, coordination efforts with an outpatient provider if relevant, and any other relevant findings.
2. Medicare Part B is an exclusionary criteria (Medicare can be billed directly).
3. Requests from an inpatient provider for ECT treatment must be submitted for review no less than three (3) business days prior to the requested start date.
4. Requests from an MHP outpatient provider for ECT treatment must be received no less than five (5) business days prior to the requested start date.
5. The IPT reviews the referral packet, confirms the individual being referred is a member of the MHP and gathers any additional information needed.
6. Once the required documentation is confirmed, the IPT sends the content of the referral packet listed above along with the following to the Sacramento County Mental Health Treatment Center (MHTC) Medical Director (or designee) for review:
   a. ECT referral packet (see contents in item 1 above).
   b. Confirmation that the individual being referred has active Medi-Cal.
   c. A copy of the individual's Diagnosis & Movement History Report from Avatar.
7. Once received, the MHTC Medical Director (or designee) will review the ECT referral packet, including the clinical rationale in order to determine medical necessity and ensure all required documentation has been submitted.
8. The MHTC Medical Director (or designee) will inform IPT if there are any concerns with authorization.
9. For approved ECT Requests, IPT will authorize initially for no more than fifteen (15) treatments within a six (6) month period.
10. Once authorized, the Intensive Placement Team (IPT) will complete the following:
    a. Maintain a record of all ECT Requests and dispositions.

   b. Enter all ECT Requests and supporting documentation into Avatar, including, but not limited to: date of receipt, authorization period, number of treatments authorized, and any additional approval needed and requests for "excessive" ECT per California Code of Regulations Title 9, Division 1, Chapter 4, Article 5 guidelines authorization.
   c. Fax the authorization for ECT to the ECT service provider (currently Sutter Center for Psychiatry).
   d. Inform the individual's inpatient/outpatient treatment provider that ECT has been authorized, along with the following information:
      i. Name and contact information for the ECT provider.
      ii. Authorization period
      iii. Number of treatments authorized.

11. To ensure payment, the ECT service provider will submit to IPT the following documentation along with invoicing for each treatment provided:
   a. Progress notes indicating coordination of care between the ECT provider and the inpatient provider or the MHP outpatient provider, who will hold primary responsibility for ongoing care in consultation with the ECT service provider.
   b. Progress notes indicating the client's response to treatment.

B. Requests for Re-Authorization for ECT

1. Requests for additional ECT sessions from an inpatient provider must be made a minimum of three (3) business days prior to the date of requested service.
2. Requests for additional ECT sessions from an outpatient provider must be made a minimum of ten (10) business days prior to the date of requested service.
3. All Re-Authorization for ECT requests will require a co-signature by the outpatient psychiatrist.
4. The referring provider completes the following and faxes to the IPT, using the fax number indicated on the Request for ECT Re-Authorization form (see Attachment C) :
   a. Request for ECT Re-Authorization form (see Attachment C)
   b. Supporting clinical documentation in recommendation of additional ECT, including the client's response to treatment.
5. IPT confirms all required documents and information is included prior to re-authorization. Once authorized, the Intensive Placement Team (IPT) will complete the following:

a. Maintain a record of all ECT Re-Authorization Requests and dispositions in Avatar.
b. Enter all ECT Requests and supporting documentation into Avatar, including, but not limited to: date of receipt, authorization period, number of treatments authorized, and any additional approval needed and received for requests for "excessive" ECT per California Code of Regulations Title 9, Division 1, Chapter 4, Article 5 guidelines authorization.
c. Fax the Re-Authorization for ECT to the ECT service provider (currently Sutter Center for Psychiatry).
d. Inform the individual's inpatient/outpatient treatment provider that ECT has been re-authorized, along with the following information:
    i. Name and contact information for the ECT provider.
    ii. Authorization period
    iii. Number of treatments authorized.

6. To ensure payment, the ECT service provider will submit to IPT the following documentation along with invoicing for each treatment provided:
    a. Progress notes indicating coordination of care between the ECT provider and the inpatient provider or the MHP outpatient provider, who will hold primary responsibility for ongoing care in consultation with the ECT service provider.
    b. Progress notes indicating the client's response to treatment.
7. Payment for all ECT services is based on authorization and submission of the documentation indicated above.

C. Excessive ECT

The IPT adheres to the California Code of Regulations, Title 9, regarding excessive ECT treatment. Specifically, "Convulsive treatments shall be considered excessive if more than fifteen (15) treatments are given to a patient within a thirty (30)-day period, or a total of more than thirty (30) treatments are given to a patient within a one year period."

1. Requests for re-authorization for additional treatments exceeding the above limits must include documentation of prior approval from the County ECT Medical Review Committee.
2. Requests for additional treatments shall include documentation of the diagnosis, the clinical findings leading to the recommendation for the additional treatments, the consideration of other reasonable treatment modalities, and the opinion that additional treatments pose less risk than other potential effective alternatives available for the particular patient at the

present time. A maximum number of additional treatments requested will be specified.

3. The ECT service provider shall provide a written copy of the contractor's internal review committee's approval of excessive ECT treatment.
4. The Mental Health Directors of the following programs will make up the standing members of the County ECT Medical Review Team:
   a. Sacramento County Mental Health Plan Medical Director (or designee)
   b. Sacramento County MHTC Medical Director

Reference(s)/Attachments:

Attachment A: Request for ECT

Attachment B: ECT Informed Consent Form

Attachment C: ECT Re-Authorization Form

Distribution:

Enter X	**DL Name**	**Enter X**	**DL Name**
X	County Mental Health Staff	**X**	Adult Contract Providers
X	Publish to Internet	**X**	Publish to Intranet

Contact Information:

Heidi Allen, LCSW, Mental Health Program Coordinator, Behavioral Health Services, (916) 875-5453, allenhe@saccounty.net

Stephanie Kelly, LMFT, Health Program Manager, Division of Behavioral Health Services, (916) 875-5878, kellyst@saccounty.net

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Sacramento County Division of Behavioral Health Services
Request for Electroconvulsive Treatment (ECT)

Client Information	
Client Name:	**Avatar ID:**
Date of Birth:	**Client Phone Number:**
Diagnosis (starting with Primary Dx):	

Referring Provider	
Submitting Program/Agency:	**Date of Request:**
Referring Psychiatrist:	**Psychiatrist Phone Number:**

Current Outpatient Provider		
Provider Agency/Program:		☐ **ECT provider is coordinating with OP provider**
Contact Person:		
Phone Number:	**Date Contacted:**	☐ **OP Provider is in agreement with ECT recommendation**

Clinical Justification for ECT: ☐ **Additional Pages Attached**

List treatment modalities used prior to the Request for ECT & client's response:

Request *must include* one of the following attachments:

☐ **ECT Informed Consent Form**
- **Voluntary Clients – signed by the client**
- **Conserved Clients – signed by the LPS Conservator**

☐ **Court Order**
- **Involuntary Clients**

Referring Psychiatrist Signature:	**Date:**

For County Use Only:

Date Request Received:

County Medical Director Name:

County Medical Director: ☐ **Approved** ☐ **Denied**

IPT: ☐ **Authorized** ☐ **Not Authorized**

Signature:

Referrals should be submitted to the Intensive Placement Team. Fax to: 916-845-8824

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ELECTROCONVULSIVE TREATMENT (ECT), INFORMED CONSENT FORM

DO NOT SIGN THIS FORM UNTIL YOU HAVE ALL THE INFORMATION YOU DESIRE CONCERNING ELECTROCONVULSIVE TREATMENT (ECT).

The nature and seriousness of my mental Condition, for which ECT is being recommended, is

____

RECOMMENDATION: I understand that ECT involves passage of an electrical stimulus across my brain for a few seconds, sufficient to induce a seizure. In my case the treatments will probably be given ________ times per week for _______ weeks, not to exceed a total of ________ treatments and not to exceed 30 days from the first treatment. Additional treatments cannot be given without my written consent.

Reasonable alternative treatments (such as psychotherapy and/or medication) have been considered and are not presently recommended by my doctor because

IMPROVEMENT: I understand that ECT may end or reduce depression, agitation and disturbing thoughts. In my case there may be permanent improvement, no improvement, or the improvement may last only a few months. Without this treatment my condition may improve, worsen or continue with little or no change.

SIDE EFFECTS AND RISKS: I understand there is a division of opinion as to the effectiveness of this treatment as well as uncertainty as to how this procedure works.

I also understand this treatment may have brief side effects: headaches, muscle soreness and confusion.

There may be some memory loss which could last less than an hour or there may be a permanent spotty memory loss. Memory loss and confusion may be lessened by the use of unilateral (one-sided) electrical brain stimulation rather than bilateral (two-sided) stimulation.

Anesthesia and muscle relaxants will be used during these treatments to prevent accidental injury. Oxygen will be administered to minimize the small risk of heart, lung, brain malfunction or death as a result of the anesthesia or treatment procedures.

My physician states I have the following medical condition(s) which increase the risk in my case, as follows:

I HAVE THE RIGHT TO ACCEPT OR REFUSE THIS TREATMENT. IF I CONSENT, I HAVE THE RIGHT TO REVOKE MY CONSENT FOR ANY REASON AT ANY TIME PRIOR TO OR BETWEEN TREATMENTS.

Dr. ______________________________ has explained the above information to my satisfaction. At least 24 hours have elapsed since the above information was explained to me. I have carefully read this form or had it read to me and understand it and the information given to me.

I HEREBY CONSENT TO ECT ____

Signature Date and Time

____

Witness Signature

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Sacramento County Division of Behavioral Health Services
Electroconvulsive Treatment (ECT) Re-Authorization

<table>
<tr><th colspan="4">Client Information</th></tr>
<tr><td colspan="3">Client Name:</td><td>Avatar ID:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Client Phone Number:</td></tr>
<tr><th colspan="4">Current Outpatient Provider</th></tr>
<tr><td colspan="3">Provider Agency/Program:</td><td rowspan="3">☐ ECT provider is coordinating with OP provider
☐ OP Provider is in agreement with ECT recommendation</td></tr>
<tr><td colspan="3">Contact Person:</td></tr>
<tr><td>Phone Number:</td><td colspan="2">Date Contacted:</td></tr>
<tr><td colspan="2">Initiation Date:</td><td colspan="2">Authorization Period End Date:</td></tr>
<tr><td colspan="4">Number of Treatments Authorized (Maximum of 15 initially):</td></tr>
<tr><td colspan="4">Initial Authorization Completed By:</td></tr>
<tr><td colspan="2">Number of ECT Treatments Completed:</td><td colspan="2">Number of ECT Treatments Requesting:</td></tr>
<tr><td colspan="3">ECT Provider Rationale to Continue Treatment (Limited to 30 sessions total per year):</td><td>☐ Additional Pages Attached</td></tr>
</table>

<table>
<tr><th colspan="3">For County Use Only:</th></tr>
<tr><td colspan="3">IPT Clinical Rationale to Continue Treatment:</td></tr>
<tr><td colspan="3">Date Request Received:
County Medical Director Name:</td></tr>
<tr><td>County Medical Director:</td><td>☐ Approved</td><td>☐ Denied</td></tr>
<tr><td>IPT:</td><td>☐ Authorized</td><td>☐ Not Authorized</td></tr>
<tr><td colspan="3">Signature:</td></tr>
</table>