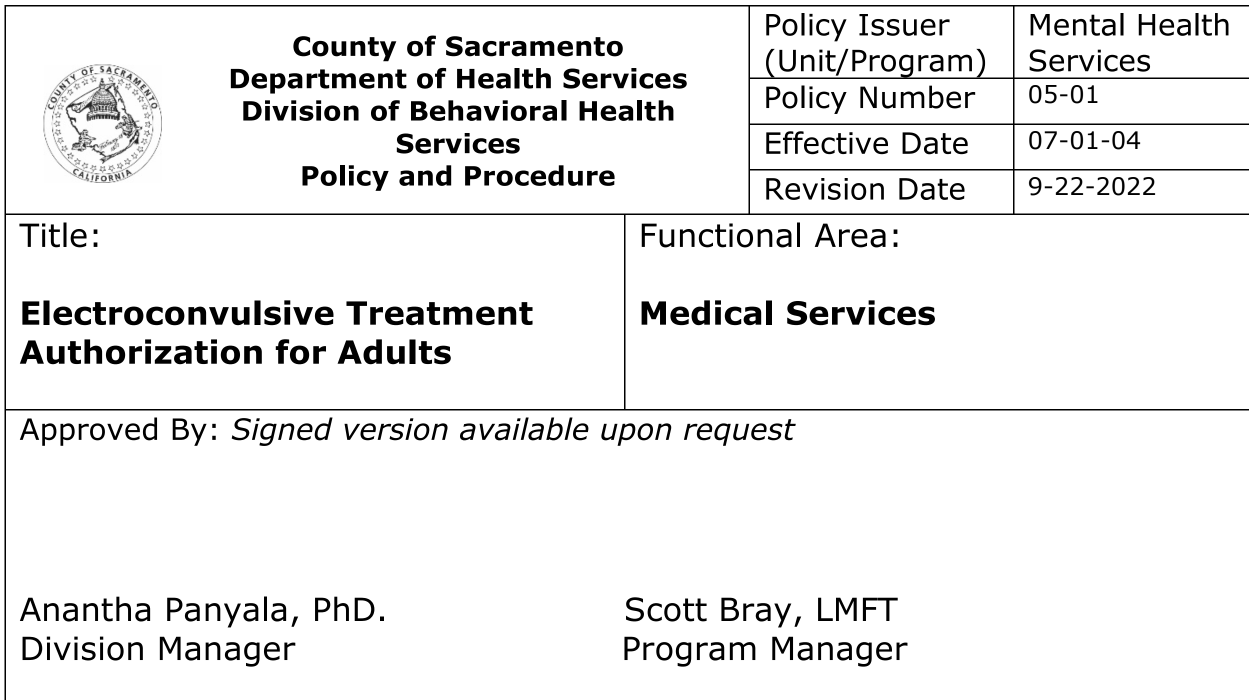

County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
	Policy Number	05-01
	Effective Date	07-01-04
	Revision Date	9-22-2022

Title: **Electroconvulsive Treatment Authorization for Adults**	Functional Area: **Medical Services**
Approved By: *Signed version available upon request*	
Anantha Panyala, PhD. Division Manager	Scott Bray, LMFT Program Manager

Background/Context:

Sacramento County Division of Behavioral Health Services (BHS) reviews and considers all requests for Electroconvulsive Therapy (ECT) for eligible adults with serious mental illness. BHS appoints an ECT Coordinator as the designated point of access and authorization for this service.

Purpose:

To establish a process for requesting, 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. Medicare Part B is an exclusionary criteria and can be billed directly to the provider.

Details:

I. Initial ECT Authorization Requests – Referring Party Responsibilities

A. Client's Clinical Treatment Team completes the ECT Referral Packet and sends to County's ECT Coordinator. The packet includes:
- Request for ECT Referral Form (Attachment A), including signature from the treating Psychiatrist.

- ECT Informed consent form (Attachment B) or court documentation indicating court authorized involuntary treatment.
- 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.

B. Submission deadlines begin upon receipt of a complete referral packet. Timeline does not begin until a completed packet has been received by the ECT Coordinator. Deadlines are as follows:
- Inpatient providers must submit requests for review no less than three (3) business days prior to the requested start date.
- Mental Health Plan (MHP) providers must submit requests for review no less than ten (10) business days prior to the requested start date.

II. Review, Authorization and Reauthorization of ECT Requests – ECT Coordinator Responsibilities

A. A complete Referral Packet, confirmation of active Medi-Cal and a copy of the client's Diagnosis and Movement History Report is submitted to a member of the BHS Medical Review Team (MRT), designated by the Director of BHS, for review.

B. A member of the MRT reviews the provided information for medical necessity and to confirm all required documentation has been submitted, then consults with the ECT Coordinator regarding any concerns.

C. If authorized, the initial authorization will include no more than fifteen (15) treatments within a six (6) month period. The ECT Coordinator shall:
- Notify the submitting party and provide them with contact information for the authorized ECT provider, the authorization period and the number of treatments authorized.
- Send the authorization for ECT to the contracted service provider.
- Maintain a record of all ECT requests and dispositions.
- Admit the patient into BHS's Electronic Health Record (EHR) and enter Service Request information and supporting documentation into the patient episode. Including but not limited to:
  - Date referral received

- ➢ Authorization Period
- ➢ Number of treatments authorized
- ➢ Any additional approval needed and requests for "excessive" ECT per California Code of Regulations (CCR) Title 9, Division 1, Chapter 4, Article 5, guidelines for authorization.

- Discharge patient from BHS's EHR when the initial 15 sessions are complete and no reauthorization has been requested within 30 days of last session.

III. Reauthorization Requests – Referring Party Responsibilities

A. Client's Clinical Treatment Team completes an ECT Request for Reauthorization packet and sends to County's ECT Coordinator. The packet includes:
- Request for ECT Re-Authorization form (Attachment C), which must be co-signed by the treating Psychiatrist.
- Supporting clinical documentation in recommendation of additional ECT, including client's response to treatment.

B. Submission deadlines begin upon receipt of a complete referral packet. Timeline does not begin until a completed packet has been received by the ECT Coordinator. Deadlines are as follows:
- Inpatient providers must submit requests at least three (3) business days prior to the date of the requested service.
- MHP outpatient providers must submit requests at least ten (10) business days prior to the date of the requested service.

C. Excessive ECT
BHS adheres to CCR Title 9 regarding excessive ECT Treatment, specifically "Convulsive treatments shall be considered excessive if more than fifteen (15) treatments are given to a patient with a thirty (30) day period, or a total of more than thirty (30) treatments are given to a patient within a one year period."

Requests for re-authorization for additional treatments exceeding the above limits must include:
- Documentation of prior approval from the BHS MRT.
- Documentation of the diagnosis, 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 this patient at the present time. A maximum number of additional treatments must be specified.

- The ECT service provider shall provide a written copy of the approval of excessive ECT treatment by their agency's internal review committee.

IV. Payment

Payment for all ECT services is based on prior authorization and submission of the documentation indicated above. The invoice and required documentation shall be submitted to the ECT Coordinator for each treatment. Required documentation includes:

- Progress notes indicating coordination of care between the ECT provider and the client's clinical treatment team, who has the primary responsibility for ongoing care in consultation with the ECT provider.
- Progress notes indicating client's response to treatment.

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:

ECT mailbox: dhs-bhsect@saccounty.gov

Carl (Scott) Bray, LMFT, Program Manager
916-875-1020
Brayc@saccounty.net

Crystal Hall, LMFT, Treatment Center Program Coordinator
ECT Coordinator
916-876-5588
HallCr@saccounty.net

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

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:		☐ OP Provider is in agreement with ECT recommendation
Phone Number:	Date Contacted:	

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**

BHS Contract Monitor: ☐ **Authorized** ☐ **Not Authorized**

Signature:

Referrals should be submitted to the BHS Contract Monitor at:
Fax: 916-854-9492
Email: DHS-BHSECT@saccounty.net

Attachment C

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

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

For County Use Only:		
Behavioral Health Services (BHS) Clinical Rationale to Continue Treatment:		
Date Request Received:		
County Medical Director Name:		
County Medical Director:	☐ Approved	☐ Denied
BHS Contract Monitor:	☐ Authorized	☐ Not Authorized
Signature:		