

Policy is terminated because Medicaid does not cover these codes.

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1.0 Description of the Procedure, Product, or Service

Electroconvulsive therapy is the electrical induction of a series of generalized seizures effective for cases of severe depression and other severe mental illnesses. The treatment consists of passing a small, carefully controlled electric current between two electrodes applied to the scalp in a unilateral or bilateral mode and thus eliciting a seizure. The recipient receives anesthesia by an anesthesiologist immediately prior to each treatment. The induction of electrical impulses is administered by a psychiatrist. The frequency and total number of treatments in any given case will vary depending on the condition being treated, the recipient's response to treatment, and the medical necessity of the treatments.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. Electroconvulsive therapy (ECT) is covered for the following:
 1. Allowable professional fees for services rendered by the attending psychiatrist and anesthesiologist are covered for any treatment authorized by the DMA's vendor.
 2. Allowable hospital services related to ECT (labs, supplies, hospital outpatient ancillaries) are covered for any treatment authorized by DMA's vendor.

Note: All benefits for ECT require prior approval. Failure to comply with the prior approval process may result in ineligibility for reimbursement. Refer to **Subsection 5.1**

- b. The following criteria will be used to determine medical necessity of electroconvulsive therapy. Criteria must:
 1. Include an established psychiatric diagnosis (ICD-9-CM or DSM IV), symptomatology, level of acuity, and documented treatment history that supports the use of ECT.
 2. Be consistent with the American Psychiatric Association clinical guidelines for ECT.
 3. Reflect the continued need and appropriateness of ECT based on the psychiatrist's on-going assessment and mental status examination of the recipient during the course of treatments

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

ECT is not covered if **Subsections 3.2** and **5.1** are not met.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for all benefits for ECT.
- b. Prior approval by DMA's vendor is required prior to the recipient receiving the first ECT treatment and prior to continuing ECT beyond the treatment already approved by DMA's vendor.
- c. DMA's vendor will conduct a clinical review with the treating provider(s) to determine the medical necessity of ECT and will review the clinical information with DMA vendor's physician. Refer to **Subsection 3.2.b**.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010	Throughout	Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."
February 29, 2012	Throughout	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Code
90870

D. Modifiers

Providers are required to follow applicable modifier guidelines

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

Allowable professional fees for services rendered by the attending psychiatrist and anesthesiologist are covered for any treatment authorized by DMA's vendor.

Allowable hospital services related to ECT (labs, supplies, hospital outpatient ancillaries) are covered for any treatment authorized by DMA's vendor.

F. Place of Service

Inpatient Hospital and Outpatient Hospital

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.