BSC8.09	Electroconvulsive Therapy		
Original Policy Date:	May 1, 2025	**Effective Date:**	May 1, 2025
Section:	8.0 Therapy	**Page:**	Page 1 of 7

Policy Statement

Note: Page numbers refer to pages within the publication by the American Psychiatric Association of The Practice of Electroconvulsive Therapy, 3rd Edition 2025, which support the use of each criterion.

I. Acute treatment electroconvulsive therapy (ECT) may be considered **medically necessary** when **ALL** of the following criteria are met:
   A. The individual has **ANY** of the following psychiatric diagnosis:
      1. Major depressive disorder (p. 8)
      2. Bipolar disorder (pp. 15, 20, 25, 30)
      3. Schizophrenia and schizoaffective disorders (pp. 17, 24, 26)
   B. The individual has a need for ECT, as indicated by **1 or more** of the following:
      1. Catatonia (pp. 15, 16)
      2. High risk for suicide attempt (pp. 6, 25)
      3. Inadequate response to pharmacotherapy (pp. 16, 32) despite **BOTH** of the following:
         a. Adequate duration and dosage or there were adverse side effects (p. 13)
         b. Medications used were appropriate to treat the primary symptoms of the condition. (p. 13)
      4. Intractable manic excitement (pp. 20, 30)
      5. Neuroleptic malignant syndrome (pp. 31, 107)
      6. Nutritional compromise (pp. 23. 82)
      7. Pharmacotherapy not preferred due to risk of adverse effects (e.g., pregnant or elderly patients) or documented intolerance (pp. 8, 71, 72)
      8. Severe self-injury (pp. 16, 32)
      9. Severe risk of harm to others (pp. 16, 32)
   C. The individual has undergone medical review and clearance (Ch. 5)
   D. The individual's pretreatment symptoms are rated as severe (pp. 16, 21, 23 – 25, 32)

II. Extension of acute treatment electroconvulsive therapy (ECT) may be considered **medically necessary** when **ALL** of the following criteria are met:
   A. The individual experienced partial positive response to acute treatment based on measurement-based scores (Sec. 18.2, pp. 235, 238, chapter 17.1, pp. 213, 214)
   B. The individual is tolerating the procedure (Sec. 18.2, p. 235)
   C. Treatment is being re-evaluated, and modification of the treatment plan is considered (e.g., switch from unilateral to bilateral lead placement, modification of stimulus parameters). (Sec. 18.2, pp. 235, 236)
   D. Evaluation of the patient's response shows measurable changes (measurement-based scores) in target symptoms and is performed on a regular basis. (Sec. 18.2, p. 235, and Sec. 17.1 pp. 213, 214, Sec. 17.2)

III. Maintenance treatment electroconvulsive therapy (ECT) may be considered **medically necessary** when **ALL** of the following criteria are met:
   A. The individual shows a response to acute course of ECT (pp. 291, 295)
   B. Documentation of a clinical rationale supporting maintenance treatment (pp. 45, 47, 48, 295)
   C. The individual experiences resistance or intolerance to pharmacotherapy alone (pp. 291, 295)
   D. The individual prefers ECT rather than medication

E. Sessions are tapered to the lowest frequency that maintains a measurable response (e.g., weekly, biweekly, monthly). (pp. 45, 47, 48, 50, see also Chapter 23)

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

Definitions:

- Positive response – at least a 50% reduction in symptom severity as measured by standardized scales.
- Partial response - at least a 25% but less than 50% reduction in symptom severity as measured by standardized scales.
- Non-response – less than 25% reduction in symptom severity as measured by standardized scales usually after 12 treatments of ECT.

Additional Information:

- Session tapering
  - Acute treatment session tapering often occurs after one week of stability in a treatment responder. In a non-responder, tapering is not medically necessary.
  - Maintenance treatment tapering is often a function of treatment response, prior treatment response, and duration of stability.

Coding
See the Codes table for details.

Description

Electroconvulsive therapy (ECT) is a safe and effective procedure to treat severe depression. It is also sometimes used to treat other forms of mental illness.

During ECT, a small amount of electricity (called an "electrical current") is passed through the brain while under general anesthesia. The current causes an intentional and brief seizure that affects the whole brain. This causes chemical changes in the brain that can relieve severe depression and quickly improve some symptoms of certain mental health conditions.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

These guidelines have been formulated based on the comprehensive work conducted by the American Psychiatric Association (APA) edition 2025 and adhere to the standards they have established. They have been adopted in their entirety to ensure compliance with Senate Bill 855 concerning health coverage for mental health or substance use disorders.

Rationale

Background, literature review, and supplemental information regarding ECT can be found in the publication The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging (3rd edition, 2025) by the American Psychiatric Association.

References

1. American Psychiatric Association. (2025). The practice of electroconvulsive therapy: Recommendations for treatment, training, and privileging (A Task Force Report of the American Psychiatric Association) (3rd ed.). American Psychiatric Pub. ISBN 978-0-89042-712-5.
2. Mayo Clinic. (2024). Electroconvulsive therapy (ECT). Accessed March 26, 2025 from https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894
3. UpToDate. Patient education: Electroconvulsive therapy (ECT) (The basics). Accessed March 26, 2025 from https://www.uptodate.com/contents/electroconvulsive-therapy-ect-the-basics?search=patient%20education%20ECT&source=search_result&selectedTitle=1%7E100&usage_type=default&display_rank=1

Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Clinical findings (i.e., pertinent symptoms and duration)
  - Comorbidities
  - Activity and functional limitations
  - Family history, if applicable
  - Reason for procedure/test/device, when applicable
  - Pertinent past procedural and surgical history
  - Past and present diagnostic testing and results
  - Prior conservative treatments, duration, and response
  - Treatment plan (i.e., surgical intervention)
- Consultation and medical clearance report(s), when applicable
- Radiology report(s) and interpretation (i.e., MRI, CT, discogram), whenever available
- Laboratory results
- Other pertinent multidisciplinary notes/reports: (i.e., psychological or psychiatric evaluation, physical therapy, multidisciplinary pain management), when applicable

Post Service (in addition to the above, please include the following):

- Results/reports of tests performed
- Procedure report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	00104	Anesthesia for electroconvulsive therapy
	4066F	Electroconvulsive therapy (ECT) provided (MDD)
	90870	Electroconvulsive therapy (includes necessary monitoring)
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
05/01/2025	New policy.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE	**AFTER** **Blue font: Verbiage Changes/Additions**
New Policy **Policy Statement:** N/A	**Electroconvulsive Therapy BSC8.09** **Policy Statement:** Note: Page numbers refer to pages within the publication by the American Psychiatric Association of The Practice of Electroconvulsive Therapy, 3rd Edition 2025, which support the use of each criterion. I. Acute treatment electroconvulsive therapy (ECT) may be considered **medically necessary** when **ALL** of the following criteria are met: A. The individual has **ANY** of the following psychiatric diagnosis: 1. Major depressive disorder (p. 8) 2. Bipolar disorder (pp. 15, 20, 25, 30) 3. Schizophrenia and schizoaffective disorders (pp. 17, 24, 26) B. The individual has a need for ECT, as indicated by **1 or more** of the following: 1. Catatonia (pp. 15, 16) 2. High risk for suicide attempt (pp. 6, 25) 3. Inadequate response to pharmacotherapy (pp. 16, 32) despite **BOTH** of the following: a. Adequate duration and dosage or there were adverse side effects (p. 13) b. Medications used were appropriate to treat the primary symptoms of the condition. (p. 13) 4. Intractable manic excitement (pp. 20, 30) 5. Neuroleptic malignant syndrome (pp. 31, 107) 6. Nutritional compromise (pp. 23. 82) 7. Pharmacotherapy not preferred due to risk of adverse effects (e.g., pregnant or elderly patients) or documented intolerance (pp. 8, 71, 72) 8. Severe self-injury (pp. 16, 32) 9. Severe risk of harm to others (pp. 16, 32) C. The individual has undergone medical review and clearance (Ch. 5)

POLICY STATEMENT	
BEFORE	**AFTER** **Blue font: Verbiage Changes/Additions**
	D. The individual's pretreatment symptoms are rated as severe (pp. 16, 21, 23 – 25, 32) II. Extension of acute treatment electroconvulsive therapy (ECT) may be considered **medically necessary** when **ALL** of the following criteria are met: A. The individual experienced partial positive response to acute treatment based on measurement-based scores (Sec. 18.2, pp. 235, 238, chapter 17.1, pp. 213, 214) B. The individual is tolerating the procedure (Sec. 18.2, p. 235) C. Treatment is being re-evaluated, and modification of the treatment plan is considered (e.g., switch from unilateral to bilateral lead placement, modification of stimulus parameters). (Sec. 18.2, pp. 235, 236) D. Evaluation of the patient's response shows measurable changes (measurement-based scores) in target symptoms and is performed on a regular basis. (Sec. 18.2, p. 235, and Sec. 17.1 pp. 213, 214, Sec. 17.2) III. Maintenance treatment electroconvulsive therapy (ECT) may be considered **medically necessary** when **ALL** of the following criteria are met: A. The individual shows a response to acute course of ECT (pp. 291, 295) B. Documentation of a clinical rationale supporting maintenance treatment (pp. 45, 47, 48, 295) C. The individual experiences resistance or intolerance to pharmacotherapy alone (pp. 291, 295) D. The individual prefers ECT rather than medication E. Sessions are tapered to the lowest frequency that maintains a measurable response (e.g., weekly, biweekly, monthly). (pp. 45, 47, 48, 50, see also Chapter 23)