**SUBMIT TO**
**Utilization Management Department**
PHONE 1.844.366.2880 | FAX 1.855.868.4940

silversummit healthplan

# ELECTROCONVULSIVE THERAPY (ECT)

## DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____

Medicaid ID#: _____

Last Auth #: _____

## PREVIOUS MH/SA TREATMENT

☐ None or ☐ OP ☐ MH ☐ SA and/or ☐ IP ☐ MH ☐ SA

List names and dates, include hospitalizations: _____

_____

Substance Use: ☐ None ☐ By History and/or ☐ Current/Active

Tobacco Use: ☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency and last used: _____

_____

Date of last Initial Diagnostic Interview (IDI): _____

Informed consent obtained from parent/ guardian? ☐ Yes ☐ No

Pre-ECT workup complete and clearance obtained? ☐ Yes ☐ No

## CURRENT ICD DIAGNOSIS

Primary: _____

Secondary: _____

Tertiary: _____

Additional: _____

Additional: _____

If the member has a substance use and/or HIV diagnosis, has a consent to release information for the related conditions been obtained? ☐ Yes ☐ No ☐ N/A

## PRIMARY CARE PROVIDER (PCP) COMMUNICATION

Has the information been shared with the PCP regarding:

- The initial evaluation and treatment plan? ☐ Yes ☐ No
- This updated evaluation and treatment plan? ☐ Yes ☐ No

PCP name and date last notified: _____

If no, explain: _____

## PROVIDER INFORMATION

Provider Name: _____

Professional Credential: ☐ MD ☐ PhD ☐ Other: _____

Address: _____

Phone: _____

Fax: _____

TNI/NPI #: _____

Tax ID#: _____

**Please indicate to whom the authorization should be made:**

☐ Individual Provider ☐ Group/ Facility

## CURRENT RISK/ LETHALITY

| | 1 None | 2 Low* | 3 Mod* | 4 High* | 5 Extreme* |
|---|---|---|---|---|---|
| Suicidal | ☐ | ☐ | ☐ | ☐ | ☐ |
| Homicidal | ☐ | ☐ | ☐ | ☐ | ☐ |
| Assault/Violent Behavior | ☐ | ☐ | ☐ | ☐ | ☐ |

***2-5 please describe what safety precautions are in place:**

_____

_____

**Please answer YES or NO to the following questions:**

- Is the member currently participating in any community based support groups/ interventions? ☐ Yes ☐ No
- Has the member's Medical Psychiatric Evaluation been completed? ☐ Yes ☐ No
- Is the member's family/ supports involved in treatment? ☐ Yes ☐ No
- Coordination of care with other behavioral health providers? ☐ Yes ☐ No
- Coordination of care with medical providers? ☐ Yes ☐ No
- Has the member been evaluated by a Psychiatrist? ☐ Yes ☐ No
- Is this member currently receiving 1915(i) SPA, 1915(c), or 1915(b)(3) waiver services? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

## CLINICAL INFORMATION

Has the member had trials of psych medication regimens? ☐ Yes ☐ No

If so, has the member has the most recent generation of medications and at adequate dosages? ☐ Yes ☐ No

Does the member have a comorbid medical condition in which prescribing psych meds would result in significant adverse effects? ☐ Yes ☐ No

**List all the medications that have been used by the member:**

Is the member's condition too acute to continue on psych meds and wait for titration? ☐ Yes ☐ No

Is the member acutely suicidal, psychotic, depressed, manic? ☐ Yes ☐ No

**What are the member's current symptoms? (socially withdrawn, decreased need for sleep, racing thoughts, severe agitation, etc.?)**

Has the member given informed consent? ☐ Yes ☐ No

Has the member's personal and family medical/psychiatric history review been done? ☐ Yes ☐ No

Has a physical examination been performed on the member? ☐ Yes ☐ No

**If so, are there any risk factors or signs of complications?**

Has the member been (or will they be) evaluated by an anesthesia provider prior to the ECT treatments? ☐ Yes ☐ No

Has the member been evaluated by an ECT-privileged psychiatrist? ☐ Yes ☐ No

Has the member previously had ECT treatment? ☐ Yes ☐ No

If so, was it successful? ☐ Yes ☐ No

## TREATMENT/ DISCHARGE GOALS

List the primary complaint/ problem to be addressed: _____

List measurable treatment goals: _____

Objectively describe how you will know the patient is ready to discontinue treatment: _____

## CURRENT RISK/ LETHALITY

| | 1 None | 2 Low* | 3 Mod* | 4 High* | 5 Extreme* |
|---|---|---|---|---|---|
| Overall progress toward goal | ☐ | ☐ | ☐ | ☐ | ☐ |
| Compliance with treatment | ☐ | ☐ | ☐ | ☐ | ☐ |
| Medical Psychiatric Eval done? (even if PCP providing meds) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Medication given by? | ☐ Psychiatrist | | ☐ PCP | ☐ N/A | |

## REQUESTED AUTHORIZATION

☐ 901 ECT

☐ 90870 ECT

Total sessions requested: _____

Frequency of Visits: _____

CPT Codes: _____

Estimated # of sessions to complete treatment episode: _____

Requested Start Date: _____

Requested End Date: _____

For applicable service requests, please include the following information and corresponding clinical documentation:

LOCUS/CASII Score _____ Intensity of Needs Level _____

_____ _____ _____

Clinician Signature | Clinician Name | Date