OPTUM®

United Behavioral Health

Coverage Determination Guideline: Substance Related Disorders

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INTRODUCTION

Coverage Determination Guidelines are a set of objective and evidence-based behavioral health criteria used by Commercial plans that don't have a provision for medical necessity to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum® [1].

INSTRUCTIONS FOR USE

This guideline provides assistance in interpreting UnitedHealthcare Commercial benefit plans, and is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

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[1] Optum is a brand used by United Behavioral Health and its affiliates.

Available benefits for Substance-Related Disorders include the following levels of care, procedures, and conditions:

- Levels of Care
    - Inpatient
    - Intensive Outpatient Program
    - Outpatient
    - Partial Hospital Program
    - Residential Treatment Facility
- Procedures
    - Diagnosis, evaluation, assessment, and treatment planning
    - Treatment and/or procedures
    - Medication management and other associated treatments
    - Individual, family, and group therapy
    - Provider-based case management
    - Crisis intervention
- Conditions
    - Depressive Disorders classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* that are not excluded from coverage.

Gambling Disorder as a principal diagnosis, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, is typically excluded. In this instance, indications for coverage are limited to circumstances where:

- Gambling Disorder is a secondary diagnosis; and
- The principal diagnosis is a covered condition; and
- Treatment is primarily focused on the principal diagnosis;
  OR
- Gambling Disorder is covered by the member's benefit plan.

A principal diagnosis is defined as the condition that, after a complete evaluation, is determined to be chiefly responsible for the member seeking treatment, and also becomes the focus of clinical attention during treatment. When a person has multiple diagnoses, the first disorder listed is assumed to be the principal diagnosis, unless the provider specified otherwise (American Psychiatric Association, 2013).

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines

Indications for Coverage

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with generally accepted standards and clinical guidelines.

A. Initial evaluation common criteria and best practices
- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
    - http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
- The American Society of Addiction Medicine (ASAM) uses six dimensions of assessment for service planning and treatment across all services and levels of care (American Society of Addiction Medicine, 2013):

1) Acute intoxication and/or withdrawal potential, exploring the individual's past and current experiences of substance use and withdrawal;
2) Biomedical conditions and complications, exploring health history and current physical condition;
3) Emotional, behavioral, or cognitive conditions or complications, exploring an individual's thoughts, emotions, and mental health issues;
4) Readiness to change, exploring an individual's readiness and interest in changing;
5) Relapse, continued use, or continued problem potential, exploring an individual's unique relationship with relapse or continued use or problems;
6) Recovery/living environment, exploring an individual's recovery or living situation, and the surrounding people, places, and things.

- The results from the evaluation should determine the member's diagnosis, level of risk, treatment setting, and treatment planning goals (American Society of Addiction Medicine, 2013)

B. Screening and Assessment Tools for Substance Use Disorders
- The National Institute of Drug Abuse (NIDA) has identified the following evidence-based/validated pre-screen and full-screen tools, where applicable (National Institute of Drug Abuse, 2015):
  o NIDA-Modified ASSIST Screening Tool (NM-ASSIST);
  o CRAFFT Screening Tool;
  o Alcohol Use Disorders Identification Test (AUDIT) and Alcohol Use Disorders Identification Test-Consumption (AUDIT-C);
  o Opioid Risk Tool;
  o CAGE and CAGE-AID;
  o Drug Abuse Screen Test (DAST-10; DAST-20);
  o Clinical Opiate Withdrawal Scale (COWS)
- Additional frequently used tools include, but are not limited to:
  o Clinical Institute Withdrawal Assessment (CIWA-Ar);
  o Single Alcohol Screening Questionnaire (SASQ);
  o Addiction Severity Index (ASI) and Teen Addiction Severity Index (T-ASI);
  o Clinical Institute Narcotic Assessment (CINA)

C. Laboratory Testing (National Institute of Drug Abuse, 2015b; VA/DOD 2015):
- As indicated, testing to assess and/or monitor drug use is an important component of a treatment regimen;
- Feedback about laboratory assessments may improve patients' motivation to change and serve as a baseline to monitor treatment progress.
- See the related coverage determination guideline on drug testing: http://www.providerexpress.com > Clinical Resources > Coverage Determination Guidelines

D. Treatment planning common criteria and best practices
- Optum recognizes the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults (2016):
  o http://www.psychiatry.org > Psychiatrists > Practice > Clinical Practice Guidelines
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  4) Readiness to change, exploring an individual's readiness and interest in changing;

5) Relapse, continued use, or continued problem potential, exploring an individual's unique relationship with relapse or continued use or problems;
6) Recovery/living environment, exploring an individual's recovery or living situation, and the surrounding people, places, and things.

- Treatment plans should be reviewed often and modified to fit the patient's changing needs (National Institute on Drug Abuse, 2016)
- Whenever a medication is to be used, the treatment plan should include steps that will promote medication adherence, depending on the needs of the patient (Substance Abuse and Mental Health Services Administration, 2015)
- Adolescents' drug use and treatment needs differ from those of adults; treatment should be tailored to the unique needs of the adolescent (National Institute on Drug Abuse, 2014)

E. General Treatment
- Successful treatment may have several steps, including (National Institute on Drug Abuse, 2016):
  o Detoxification;
  o Behavioral Counseling;
  o Medication;
  o Evaluation and treatment for co-occurring mental health issues;
  o Long-term follow-up to prevent relapse.
- The earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes (National Institute on Drug Abuse, 2012)
- Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning (National Instite on Drug Abuse, 2012)
- All individuals involved in the patient's treatment should establish close linkages and open communciations (Substance Abuse and Mental Health Services Administration, 2015)
- Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment (Nation Institute on Drug Abuse, 2012)
- The following principles should be considered fundamental to the engagement/re-engagement process for patients with substance use disorder (VA/DOD, 2015):
  o Indicate to the patient and significant others that treatment is more effective than no treatment (i.e., "treatment works");
  o Consider the patient's prior treatment experience and respect patient preference for the initial intervention approach(es), since no single intervention approach has emerged as the treatment of choice;
  o Regardless of the particular psychosocial intervention chosen, use motivational interviewing style during therapeutic encounters with patients and emphasize the common elements of effective interventions including improving self-efficacy for change, promoting a therapeutic relationship, strengthening coping skills, changing reinforcement contingencies for recovery, and enhancing social support for recovery;
  o Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support for recovery;
  o Use strategies demonstrated to be efficacious to promote active involvement in available mutual help programs (e.g., Alcoholics Anonymous, Narcotics Anonymous);
  o Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems to address identified concurrent problems consistent with patient priorities;
  o Provide intervention in the least restrictive setting necessary to promote access to care, safety, and effectiveness;
  o If a patient drops out of treatment, the treatment team should make efforts to contact the patient and re-engage him/her in treatment;
  o If the patient remains unwilling to engage in any addiction-focused care, determine whether treatment for medical and psychiatric problems can be effectively and safely provided while looking for windows of opportunity to engage the patient in addiction treatment.

- Recovery support services designed to initiate, support and enhance recovery should be implemented alongside treatment services (e.g., helping member access supportive living environment, participation in peer support services, involvement in wraparound services that may influence the treatment success) (American Society of Addiction Medicine, 2013)
- Some patients may respond to psychosocial interventions and others to medication therapy alone, but most patients benefit from a combination of these approaches (Substance Abuse and Mental Health Services Administration, 2015)

F. Psychosocial Interventions
- Behavioral therapies help patients modify their attitudes and behaviors related to drug use and increase healthy life skills (National Institute on Drug Abuse, 2016)
- Psychosocial approaches to treatment can be provided at the individual or group level. Some common therapies include (e.g., Substance Abuse and Mental Health Services Administration, 2016):
  - Cognitive behavioral-therapy, which teaches the individual to recognize and stop negative thinking and behavior patterns;
  - Contingency management, such as providing incentives to reinforce positive behaviors;
  - Motivational enhancement therapy, which is often used early in the process to build motivation and commit to specific plans to engage in treatment and seek recovery;
  - Peer support group programs, including 12-step programs such as Alcoholics Anonymous or Narcotics Anonymous.
- There is considerable evidence from psychotherapy research that general factors such as therapist skill, the strength of the therapeutic alliance, and the structure provided by regular clinical contact can have a powerful effect on engagement (VA/DOD, 2015)

G. General Pharmacotherapy
- Medications are often an important part of treatment, especially when combined with counseling and other behavioral therapies (National Institute on Drug Abuse, 2016; National Institute on Drug Abuse, 2012). Pharmacotherapy as part of the member's treatment and recovery may be used to:
  - Re-establish normal brain function and decrease cravings (National Institute on Drug Abuse, 2016) and/or
  - Treat co-occurring medical and/or psychiatric conditions
- Medication Assisted Treatment (MAT) or Medication Assisted Recovery (MAR) approaches may involve pharmacotherapy to support recovery and treatment interventions (Substance Abuse and Mental Health Services Administration, 2015)
  - Patients with moderate or severe alcohol use disorder, including those who have physiologic dependence or who are experiencing cravings and have not improved in response to psychosocial approaches alone, are particularly strong candidates for medication-assisted treatment (Substance Abuse and Mental Health Services Administration, 2015)
  - In addition to factors specific to each medication, the clinician should consider the patient's past experience with particular medication-assisted treatment medications; beliefs and opinions about which pharmacotherapy may be most helpful; level of motivation for abstinence; medical status and contraindications for each medication; and history of medication adherence (Substance Abuse and Mental Health Services Administration, 2015)
- See the related coverage determination guideline on office-based treatment of opioid dependence: http://www.providerexpress.com > Clinical Resources > Coverage Determination Guidelines

H. Withdrawal Management/Detoxification
- Patients needing medically supervised detoxification may need to be referred to an addiction specialist or addiction treatment program that can provide medically monitored withdrawal treatment (Substance Abuse and Mental Health Services Administration, 2015)

- In assessing the likelihood and potential severity of withdrawal, the most useful clinical factors are the patient's previous withdrawal experience and the number of previous withdrawals (Substance Abuse and Mental Health Services Administration, 2015)
- Withdrawal management/detoxification medications help suppress withdrawal symptoms during detoxification (National Institute on Drug Abuse, 2016)
- Detoxification is not in itself "treatment", but only a first step in the process – patients not receiving any further treatment after detoxification are likely to resume their drug use (National Institute on Drug Abuse, 2016)
  - Patients should be encouraged to continue drug treatment following detoxification (National Institute on Drug Abuse, 2012)
- Specific attention should be given to the medication evaluation and management of members with active psychiatric and/or medical symptoms (American Society of Addiction Medicine, 2013)

I. Monitoring Patient Progress
- An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs (National Institute on Drug Abuse, 2012)
- Drug use during treatment must be monitored continuously, as lapses during treatment do occur (National Institute on Drug Abuse, 2012)
  - Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs (National Institute on Drug Abuse, 2012)
- Monitoring patient progress for treatment of alcohol use disorder is an ongoing process, during which the patient is assessed on three dimensions (Substance Abuse and Mental Health Services Administration, 2015):
  - Adherence to the treatment plan;
  - Ability to maintain abstinence or reduced drinking, duration of periods of abstinence or reduced drinking, and levels of craving;
  - Overall health status and social functioning
- If a patient begins to experience problems with adherence, the clinician should assess the patient for underlying medical, psychiatric, or social factors and revisit the treatment plan to determine whether different strategies or treatment modalities may be useful (Substance Abuse and Mental Health Services Administration, 2015)

J. Managing Relapse
- Relapse does not indicate that treatment has failed, but signals that it may need to be adjusted, reinstated, or changed in order to move toward recovery (VA/DOD, 2015)
- Evidence is accumulating that brief counseling sessions combined with use of a medication is an effective treatment for many patients in early recovery (Substance Abuse and Mental Health Services Administration, 2015)
  - Counseling sessions typically focus on encouraging abstinence, adherence to the medication regimen, and participation in mutual-help groups and other peer support programs (Substance Abuse and Mental Health Services Administration, 2015; National Institute on Drug Abuse, 2012)
- If patients receiving treatment for alcohol use disorder relapse, the provider should consider several options, including (Substance Abuse and Mental Health Services Administration, 2015):
  - Examining social, medical, or behavioral factors that contribute to the patient's alcohol consumption;
  - Increased monitoring;
  - Adjusting the dose of medication;
  - Increasing or changing the intensity of psychosocial services;
  - Referring the patient for specialty care.

K. Gambling Disorder Assessment and Treatment
- Gambling can affect individuals in varying ways, and certain approaches may work better for certain people (American Psychiatric Association, 2016).

- The South Oaks Gambling Screen (SOGS) is a 16-item instrument used to "rule in" or "rule out" an individual as someone with problem-gambling. If the member is "ruled in", the next step would be to perform a comprehensive diagnostic assessment (American Society of Addiction Medicine, 2013)
- Assessment of the member's gambling behavior includes (American Society of Addiction Medicine, 2013):
  - Initiation;
  - Progression;
  - Current freuqncy, severity, types of games played, maintaining factors, and features of dependence;
  - Consequences (financial, interpersonal, vocational, etc);
  - Reasons for consultation and motivation to change;
  - Assessment of suicide risk;
  - Comorbidities;
  - Confirmation of the diagnosis;
- Pathological gambling can be highly comorbid with substance use, mood, anxiety, and personality disorders (Petry, et al 2005)
- Once a diagnosis is confirmed, determining the severity of the illness can be used to guide the intensity of the intervention(s) developed as part of the treatment plan (American Society of Addiction Medicine, 2013)
- Various therapies may be used to treat gambling disorder, particularly cognitive behavioral therapy; however, the durability of therapeutic gain is largely unknown (Cowlishaw, et al 2012).

APPLICABE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

Diagnosis Codes	Description
305.0x; 303.9x	Alcohol Use Disorder (mild, moderate, severe)
303.0x	Alcohol intoxication
291.81	Alcohol Withdrawal
305.9x	Caffeine Intoxication
292.0	Caffeine Withdrawal
305.2x; 304.3x	Cannabis Use Disorder (mild, moderate, severe)
292.89	Cannabis Intoxication
292.0	Cannabis Withdrawal
305.9x; 304.6x	Phencyclidine Use Disorder (mild, moderate, severe)
305.3x; 304.5x	Other Hallucinogen Use Disorder (mild, moderate, severe)
292.89	Phencyclidine Intoxication
292.89	Other Hallucinogen Intoxication
292.89	Hallucinogen Persisting Perception Disorder
305.9x; 304.6x	Inhalant Use Disorder (mild, moderate, severe)
292.89	Inhalant Intoxication
305.5x; 304.0x	Opioid Use Disorder (mild, moderate, severe)
292.89	Opioid Intoxication

292.0	Opioid Withdrawal
305.4x; 304.1x	Sedative, Hypnotic, or Anxiolytic Use Disorder (mild, moderate, severe)
292.89	Sedative, Hypnotic, or Anxiolytic Intoxication
292.0	Sedative, Hypnotic, or Anxiolytic Withdrawal
305.7x; 305.6x (mild); 304.4x; 304.2x (moderate; severe)	Stimulant Use Disorder (amphetamine; cocaine; other stimulant)
292.89	Stimulant Intoxication
292.0	Stimulant Withdrawal
305.1	Tobacco Use Disorder
292.0	Tobacco Withdrawal
312.31	Gambling Disorder

Procedure Codes	Description
90785	Interactive complexity Psychiatry Services & Procedures (list separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service(list separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to the code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes
G0411	Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes
H0004	Behavioral health counseling and therapy, per 15 minutes

H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H2001	Rehabilitation program, per 1/2 day
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2019	Therapeutic behavioral services, per 15 minutes
H2020	Therapeutic behavioral services, per diem
H2033	Multisystemic therapy for juveniles, per 15 minutes
S0201	Partial hospitalization services, less than 24 hours, per diem
S9480	Intensive outpatient psychiatric services, per diem
S9482	Family stabilization services, per 15 minutes
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

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REVISION HISTORY

Date	Action/Description
11/2016	• Version 1
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