

# SUBSTANCE-RELATED AND ADDICTIVE DISORDERS

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Relevant Diagnoses:
• Alcohol-Related Disorders
• Caffeine-Related Disorders
• Cannabis-Related Disorders
• Hallucinogen-Related Disorders
• Inhalent-Related Disorders
• Opioid-Related Disorders
• Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
• Stimulant-Related Disorders
• Tobacco-Related Disorders
• Gambling Disorder
Related Clinical Policies and Guidelines:
• Drug Testing
• Opioid Treatment Program (Methadone Maintenance)
• Office-Based Treatment of Opioid Dependence
• Other Specified and Unspecified Disorders

## BENEFIT CONSIDERATIONS

**Before using this policy, please check the member’s specific benefit plan requirements and any federal or state mandates, if applicable.**

### Pre-Service Notification

Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision for a grace period before applying a penalty for failure to notify Optum as required.

## COVERAGE RATIONALE

Available benefits for **substance-related disorders** include the following services:

- Diagnostic evaluation, assessment, and treatment planning
- Treatment and/or procedures
- Medication management and other associated treatments
- Individual, family, and group therapy
- Provider-based case management services
- Crisis intervention

**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).

## EVIDENCE-BASED CLINICAL GUIDELINES

### A. Initial evaluation common criteria and best practices

- See "*Common Criteria and Best Practices for All Levels of Care*", available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>
- 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 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, 2017 ):
  - NIDA Drug Use Screening Tool: Quick Screen;
  - CRAFFT Screening Tool;
  - Alcohol Use Disorders Identification Test (AUDIT) and Alcohol Use Disorders Identification Test-Consumption (AUDIT-C);
  - Opioid Risk Tool;
  - CAGE and CAGE-AID;
  - Drug Abuse Screen Test (DAST-10; DAST-20);
  - Others that are not listed
- Additional frequently used tools include, but are not limited to:
  - Clinical Institute Withdrawal Assessment (CIWA-Ar);
  - Single Alcohol Screening Questionnaire (SASQ);
  - Addiction Severity Index (ASI) and Teen Addiction Severity Index (T-ASI);
  - 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

- See "*Common Criteria and Best Practices for All Levels of Care*", available at: <https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>
- 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.
- 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):
  - Detoxification;
  - Behavioral Counseling;
  - Medication;
  - Evaluation and treatment for co-occurring mental health issues;
  - 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 Institute on Drug Abuse, 2012)
- All individuals involved in the patient's treatment should establish close linkages and open communications (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 (National 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):
  - Indicate to the patient and significant others that treatment is more effective than no treatment (i.e., "treatment works");
  - 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;
  - 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;
  - Emphasize that the most consistent predictors of successful outcome are retention in formal treatment and/or active involvement with community support for recovery;
  - Use strategies demonstrated to be efficacious to promote active involvement in available mutual help programs (e.g., Alcoholics Anonymous, Narcotics Anonymous);
  - Coordinate addiction-focused psychosocial interventions with evidence-based intervention(s) for other biopsychosocial problems to address identified concurrent problems consistent with patient priorities;
  - Provide intervention in the least restrictive setting necessary to promote access to care, safety, and effectiveness;
  - If a patient drops out of treatment, the treatment team should make efforts to contact the patient and re-engage him/her in treatment;
  - 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 frequency, 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 (Cowlshaw, et al 2012).

#### L. Discharge planning common criteria and best practices

See "Common Criteria and Best Practices for All Levels of Care":

<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

## APPLICABLE 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 guideline 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 policies and guidelines may apply.

CPT Code	Description
90785	Interactive complexity (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)
90847	Family psychotherapy (conjoint psychotherapy) (with the patient present)
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)

HCPCS Code	Description
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



HCPCS Code	Description
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

ICD-10 Diagnosis Code or Range	Description
F10.10 - F10.99	Alcohol related disorders
F11.10 – F11.99	Opioid related disorders
F12.10 - F12.99	Cannabis related disorders
F13.10 - F13.99	Sedative, hypnotic, or anxiolytic related disorders
F14.10 – F14.99	Cocaine related disorders
F15.10 – F15.99	Other stimulant related disorders
F16.10 – F16.99	Hallucinogen related disorders
F17.200 – F17.299	Nicotine dependence
F18.10 – F18.99	Inhalant related disorders
F19.10 – F19.99	Other psychoactive substance related disorders
F63.0	Pathological gambling

## LEVEL OF CARE GUIDELINES

**Optum / OptumHealth Behavioral Solutions of California Level of Care Guidelines are available at:**  
<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/locg.html>

*The Level of Care Guidelines are a set of objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing.*

## UNITEDHEALTHCARE BENEFIT PLAN DEFINITIONS

**For plans using 2001 and 2004 generic UnitedHealthcare COC/SPD, unless otherwise specified**  
 Covered Health Service(s)

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in *Section 1: What's Covered--Benefits as a Covered Health Service*, which is not excluded under *Section 2: What's Not Covered--Exclusions*.

**For plans using 2007 and 2009 generic UnitedHealthcare COC/SPD, unless otherwise specified**  
*Covered Health Service(s)*

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in the *Certificate of Coverage* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in the *Certificate of Coverage* under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

**For plans using 2011 and more recent generic UnitedHealthcare COC/SPD, unless otherwise specified**  
*Covered Health Care Service(s)* - health care services, including supplies or Pharmaceutical Products, which we

determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate* under *Section 2: Exclusions and Limitations*.

*Medically Necessary* - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Doctor specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Doctor specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

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\*Additional reference materials can be found in the reference section(s) of the applicable Level of Care Guidelines

#### GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
11/2016	<ul style="list-style-type: none"><li>Version 1 - Approved by UM Committee</li></ul>
1/10/2018	<ul style="list-style-type: none"><li>Annual review performed. Formatting updated: instructions for use removed, benefit considerations condensed, plan definitions removed, links to common criteria removed, DSM classification removed and additional resources section removed. Coding and references updated. No substantive changes to clinical content.</li></ul>