

# Treatment of Substance-Related & Addictive Disorders

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2001 Generic UnitedHealthcare COC/SPD

2007 Generic UnitedHealthcare COC/SPD

2009 Generic UnitedHealthcare COC/SPD

2011 Generic UnitedHealthcare COC/SPD

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**Related Coverage Determination Guidelines:**

Custodial Care and Inpatient Services  
Office Based Opioid Treatment  
Opioid Treatment Program

**Related Medical Policies:**

Level of Care Guidelines  
American Academy of Child and Adolescent Psychiatry. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders, 2005  
American Psychiatric Association, Practice Guideline for the Treatment of Patients with Substance Use Disorders, 2006  
American Psychiatric Association, Practice Guideline Watch for the Treatment of Patients with Substance Use Disorders, 2007  
American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions, Third Edition, 2013

**INSTRUCTIONS FOR USE**

*This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California (doing business as Optum California ("Optum-CA")).*

*When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee's document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee's specific benefit document supersedes these guidelines.*

*All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements that supersede the COC/SPD and the plan benefit coverage prior to use of this guideline. Other coverage determination guidelines and clinical guideline may apply.*

*Optum reserves the right, in its sole discretion, to modify its coverage determination guidelines and clinical guidelines as necessary.*

*While this Coverage Determination Guideline does reflect Optum's understanding of current best practices in care, it does not constitute medical advice.*

### **Key Points**

- According to the DSM, the essential feature of a Substance-Related Disorder is a problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period (*Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> ed.*; DSM-5; American Psychiatric Association, 2013):
  - The substance(s) is taken in larger amounts or over a longer period than was intended;
  - There is a persistent desire or unsuccessful efforts to cut down or control substance use;
  - A great deal of time is spent in activities necessary to obtain substances, use substances, or recover from the effects of substance use;
  - Craving, or a strong desire or urge to use substances;
  - Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home;
  - Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance(s);
  - Important social, occupational, or recreational activities are given up or reduced because of substance use;
  - Recurrent use in situations in which it is physically hazardous;
  - Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance use;
  - Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of substances to achieve intoxication or desired effect;
    - A markedly diminished effect with continued use of the same amount.
  - Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for the substance used according to DSM-5;
    - Other substances are used to relieve or avoid withdrawal symptoms.

- Benefits are available for covered services that are not otherwise limited or excluded.
- Pre-notification is required for inpatient rehabilitation, inpatient detoxification, residential rehabilitation, residential detoxification, partial hospital/day treatment program or intensive outpatient programs (UnitedHealthcare Certificate of Coverage (COC), 2007, 2009 & 2011).
- Services should be consistent with evidence-based interventions and clinical best practices as described in Part II, and should be of sufficient intensity to address the member's needs (COC, 2007, 2009 & 2011).

## **PART I: BENEFITS**

Before using this guideline, please check enrollee's specific plan document and any federal or state mandates, if applicable.

### **Benefits**

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

### **Covered Services**

#### **Covered Health Service(s) – 2001**

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.

#### **Covered Health Service(s) – 2007, 2009 and 2011**

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 this 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.

### **Pre-Service Notification**

Admissions to an inpatient detoxification, residential detoxification, inpatient rehabilitation, residential rehabilitation, partial hospital/day treatment program or intensive outpatient programs 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.

### **Limitations and Exclusions**

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee's benefit document, or is otherwise defined differently, it is the terms of the enrollee's benefit document that prevails.

#### **Inconsistent or Inappropriate Services or Supplies – 2001, 2007, 2009 & 2011**

Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance-Related Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.

- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance-Related Disorder Designee’s level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member’s Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

### **Additional Information**

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all-inclusive list):

- Services that deviate from the indications for coverage summarized earlier in this document.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program without evidence-based treatment of acute symptoms.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program for the sole purpose of awaiting placement in a long-term facility.
- Admission to an inpatient, residential treatment, partial hospital/day treatment program or intensive outpatient program that does not provide adequate nursing care and monitoring, or physician coverage.

Please refer to the enrollee’s benefit document for ASO plans with benefit language other than the generic benefit document language.

## **PART II: CLINICAL BEST PRACTICE**

### **Evaluation and Treatment Planning**

#### **1. The initial evaluation:**

- 1.1. Gathers information about the presenting issues from the member’s perspective, and includes the member’s understanding of the factors that lead to requesting services (i.e., the “why now” factors).
- 1.2. Focuses on the member’s specific needs.
- 1.3. Identifies the member’s goals and expectations.
- 1.4. Is completed in a timeframe commensurate with the member’s needs, or otherwise in accordance with clinical best practices.

- 1.5. The provider collects information from the member and other sources, and completes an initial evaluation of the following:
  - 1.5.1.1. The member's chief complaint;
  - 1.5.1.2. The history of the presenting illness;
  - 1.5.1.3. The "why now" factors leading to the request for service;
  - 1.5.1.4. The member's mental status;
  - 1.5.1.5. The member's current level of functioning;
  - 1.5.1.6. Urgent needs including those related to the risk of harm to self, others, or property;
  - 1.5.1.7. The member's use of alcohol, tobacco, or drugs;
  - 1.5.1.8. Co-occurring behavioral health and physical conditions;
  - 1.5.1.9. The history of behavioral health services;
  - 1.5.1.10. The history of trauma;
  - 1.5.1.11. The member's medical history and current physical health status;
  - 1.5.1.12. The member's developmental history;
  - 1.5.1.13. Pertinent current and historical life information including the member's :
    - 1.5.1.13.1. Age;
    - 1.5.1.13.2. Gender, sexual orientation;
    - 1.5.1.13.3. Culture;
    - 1.5.1.13.4. Spiritual beliefs;
    - 1.5.1.13.5. Educational history;
    - 1.5.1.13.6. Employment history;
    - 1.5.1.13.7. Living situation;
    - 1.5.1.13.8. Legal involvement;
    - 1.5.1.13.9. Family history;
    - 1.5.1.13.10. Relationships with family, friends and others;
  - 1.5.1.14. The member's strengths;
  - 1.5.1.15. Barriers to care;
  - 1.5.1.16. The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
  - 1.5.1.17. The member's broader recovery, resiliency and wellbeing goals.

## 2. Substance Use Evaluation

- 2.1. According to the ASAM Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (ASAM Criteria) (2013) a comprehensive assessment should include and evaluation of all of the following six dimensions:
  - 2.1.1. Acute intoxication and/or withdrawal potential exploring the individual's past and current experiences of substance use and withdrawal.
  - 2.1.2. Biomedical conditions and complications exploring health history and current physical condition.
  - 2.1.3. Emotional, behavioral or cognitive conditions or complications, exploring an individual's thoughts, emotions, and mental health issues.
  - 2.1.4. Readiness to change exploring an individual's readiness and interest in changing.
  - 2.1.5. Relapse, continued use, or continued problem potential exploring an individual's unique relationship with relapse or continued use or problems.
  - 2.1.6. Recovery/Living environment exploring an individual's recovery or living situation, and the surrounding people, places and things.
- 2.2. Symptom screening that includes the use of screening tools and structured interviews. According to the Substance Abuse and Mental Health Services Administration (SAMHSA TIP 31) Treatment Improvement Protocol 31, Screening and Assessment Instruments (2011), the tools that may be used include:
  - 2.2.1. The Drug Abuse Screening Test (DAST), the Addiction Severity Index (ASI),
  - 2.2.2. The Structured Clinical Interview (SCID),
  - 2.2.3. The Stages of Readiness and Treatment Eagerness Scale (SOCRATES),
  - 2.2.4. The Clinical Institute Withdrawal Assessment (CIWA-Ar) if applicable,
  - 2.2.5. The Alcohol Use Disorders Identification Test (AUDIT) and The Alcohol Use Disorders Identification Test Consumption (AUDIT-C) if applicable,
  - 2.2.6. Single Alcohol Screening Questionnaire (SASQ) (VA/DoD, 2009).
  - 2.2.7. Clinical Opiate Withdrawal Scale (COWS), if applicable,

- 2.2.8. The Drug and Alcohol Problem Screening for adolescents (DAP) if applicable,
- 2.2.9. The Teen Addiction Severity Index (T-ASI) for adolescents if applicable,
- 2.2.10. The Adolescents Diagnostic Interview (ADI), if applicable.
- 2.3. In addition the above tools, when applicable, the ASAM Criteria (2013) recommends the use of the Clinical Institute Narcotic Assessment (CINA) to measure the signs and symptoms commonly seen in patients with narcotic withdrawal.
- 2.4. Toxicology and laboratory testing as needed (American Psychiatric Association Practice Guideline for the Treatment of Substance Use Disorders (APA Guideline), 2006);
  - 2.4.1. Blood, urine and other laboratory tests for abnormalities that may accompany acute or chronic substance use should be taken. These tests may also be used during treatment to monitor potential for relapse. Breath tests may also be useful in assessing alcohol use.
  - 2.4.2. Screening for infectious disease such as HIV and Hepatitis C may also be necessary
  - 2.4.3. Consider whether pregnancy testing or diagnostic testing for additional medical conditions is required (APA Guideline, 2006);
- 2.5. Gather a comprehensive substance abuse treatment history including onset and pattern of progression and past treatment episodes for substance use (VA/DoD, 2009).
- 2.6. Recent pattern of substance abuse based on self-report (VA/DoD, 2009).
- 2.7. Contact family and significant others for collateral information (APA Guideline, 2006);
- 2.8. Determine access to a supportive recovery environment, difficulties with family and social relationships, unemployment/underemployment, or unresolved legal issues (VA/DoD, 2009).
- 2.9. The results from the evaluation should determine the member's diagnosis, level of risk, treatment setting and treatment planning goals (ASAM Criteria, 2013).

### **3. Treatment Planning**

- 3.1. The provider and, whenever possible, the member use the findings of the initial evaluation and the diagnosis to develop a treatment plan. The treatment plan addresses:

- 3.1.1. The short- and long-term goals of treatment;
  - 3.1.2. The type, amount, frequency and duration of treatment;
  - 3.1.3. The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed and directly related to the “why now” factors;
  - 3.1.4. How the member’s family and other natural resources will participate in treatment when clinically indicated;
  - 3.1.5. How treatment will be coordinated with other providers as well as with agencies or programs with which the member is involved.
- 3.2. As needed, the treatment plan also includes interventions that enhance the member’s motivation, promote informed decisions, and support the member’s recovery, resiliency, and wellbeing.
  - 3.2.1. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- 3.3. The provider informs the member of safe and effective treatment alternatives, as well as the potential risks and benefits of the proposed treatment. The member gives informed consent acknowledging willingness and ability to participate in treatment and abide by safety precautions.
- 3.4. Treatment focuses on addressing the “why now” factors to the point that the member’s condition can be safely, efficiently, and effectively treated in a less intensive level of care, or the member no longer requires care.
- 3.5. The treatment plan and level of care are reassessed when the member’s condition improves, worsens or does not respond to treatment.
  - 3.5.1. When the member’s condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
  - 3.5.2. When the member’s condition has worsened or not responded to treatment, the provider verifies the diagnosis, alters the treatment plan, or determines if the member’s condition should be treated in another level of care.
- 3.6. In the event that all information is unavailable at the time of the evaluation, there must be enough information to provide a basis for the diagnosis, guide the development of the treatment plan, and support the need for treatment in the proposed level of care.

## 4. Psychosocial Interventions

- 4.1. Individual and/or group psychotherapy can help patients reduce the frequency and amount of substances used. Individual therapy can be provided in many types of treatment settings. Group therapy is one of the most common psychosocial interventions used to treat substance use (ASAM Criteria, 2013).
- 4.2. Individual and group interventions such as Cognitive Behavior Therapy (CBT), Motivational Enhancement Therapy (MET), and other behavior therapies appropriate for the member's stage of "readiness to change" are appropriate first line interventions (APA Guideline, 2006).
- 4.3. Motivational Enhancement Therapy (MET) appropriate for member's stage of "readiness to change" propel members to make changes in their lives by guiding them through several stages of change that are typical of people thinking about, initiating, and maintaining new behaviors. When applied to substance abuse treatment, motivational interventions can help members move from not changing their behavior to being ready, willing, and able to do so. (Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol 35 (SAMHSA TIP 35) Motivational Enhancement, 2011).
  - 4.3.1. All MET interventions are based on the member's readiness to change according to the following stages (SAMHSA TIP 35, 2011):
    - 4.3.1.1. Pre-contemplation Stage interventions include:
      - 4.3.1.1.1. Establishing rapport, asking permission, and building trust to engage the member.
      - 4.3.1.1.2. Raising doubts or concerns in the member about substance-using patterns.
      - 4.3.1.1.3. Exploring the meaning of events that brought the member to treatment or the results of previous treatments.
      - 4.3.1.1.4. Eliciting the member's perceptions of the problem.
      - 4.3.1.1.5. Offering factual information about the risks of substance use and;
      - 4.3.1.1.6. Expressing concern and keeping the door open.
    - 4.3.1.2. Contemplation Stage interventions include:
      - 4.3.1.2.1. Normalizing ambivalence.

- 4.3.1.2.2. Helping the member "tip the decisional balance scales" toward change by eliciting and weighing pros and cons of substance use and change, changing extrinsic to intrinsic motivation, examining the member's personal values in relation to change and emphasizing the member's free choice, responsibility, and self-efficacy for change and;
- 4.3.1.2.3. Eliciting self-motivational statements of intent and commitment from the member.
- 4.3.1.3. Preparation Stage interventions include:
  - 4.3.1.3.1. Clarifying the member's own goals and strategies for change.
  - 4.3.1.3.2. Offering a menu of options for change or treatment.
  - 4.3.1.3.3. With permission, offering expertise and advice.
  - 4.3.1.3.4. Negotiating a change and behavior contract.
  - 4.3.1.3.5. Considering and lowering barriers to change.
  - 4.3.1.3.6. Helping the member enlist social support.
  - 4.3.1.3.7. Exploring treatment expectations and the member's role.
  - 4.3.1.3.8. Eliciting from the member what has worked in the past.
  - 4.3.1.3.9. Assisting the member to negotiate finances, child care, work, transportation, or other potential barriers.
  - 4.3.1.3.10. Having the member publicly announce plans to change.
- 4.3.1.4. Action Stage interventions include:
  - 4.3.1.4.1. Engaging the member in treatment and reinforcing the importance of remaining in recovery.
  - 4.3.1.4.2. Supporting a realistic view of change through small steps.
  - 4.3.1.4.3. Acknowledging difficulties for the member in early stages of change.
  - 4.3.1.4.4. Helping the member identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these.
  - 4.3.1.4.5. Assisting the member in finding new reinforcers of positive change.
  - 4.3.1.4.6. Helping the member assess whether he or she has strong family and social support.

4.3.1.5. Maintenance Stage interventions include:

- 4.3.1.5.1. Helping the member identify and sample drug-free sources of pleasure (i.e., new reinforcers).
- 4.3.1.5.2. Supporting lifestyle changes.
- 4.3.1.5.3. Affirming the member's resolve and self-efficacy.
- 4.3.1.5.4. Helping the member practice and use new coping strategies to avoid a return to use.
- 4.3.1.5.5. Maintaining supportive contact (e.g., explain to the member that you are available to talk between sessions).
- 4.3.1.5.6. Developing a plan if the member resumes substance use or if the relapse prevention plan fails.
- 4.3.1.5.7. Reviewing long-term goals with the member.

4.3.1.6. Recurrence Stage interventions include:

- 4.3.1.6.1. Helping the member reenter the change cycle and commending any willingness to reconsider positive change.
- 4.3.1.6.2. Exploring the meaning and reality of the recurrence as a learning opportunity.
- 4.3.1.6.3. Assisting the member in finding alternative coping strategies.
- 4.3.1.6.4. Maintaining supportive contact.

4.4. Cognitive Behavioral Therapy (CBT) may also be implemented. CBT is a structured goal-directed form of psychotherapy in which patients learn how their thought processes contribute to their behavior. Increased cognitive awareness is combined with techniques to help patients develop new and adaptive ways of behaving and alter their social environment, which in turn leads to change in thoughts and emotions (Aronson, 2015).

4.5. The goal of CBT is to target cognitive processes that lead to maladaptive behaviors, to intervene in the chain of events leading to substance use, to help reduce acute or chronic craving and to promote and reinforce the development of effective social skills and behaviors (APA Guideline, 2006).

4.5.1. CBT interventions for Substance Use Disorders typically combine traditional CBT methods with social skills training and relapse prevention methods.

4.5.2. Focused on a rewards approach, utilizing the member's interactions with family, employers, court system or random drug testing as measures of progress.

- 4.5.3. Members may be introduced to support groups, group therapy and other self-help methods in preparation for the next, most appropriate level of care.
- 4.5.4. The participation of family and/or important supportive individuals in the treatment process will help provide the member with a support network, foster the treatment process and strengthen the member's recovery environment (ASAM Criteria, 2013).
- 4.5.5. Acutely intoxicated members should be provided with decreased exposure to external stimuli, reassurance, reorientation, and reality testing that is safe and closely monitored alongside CBT and MET interventions (ASAM Criteria, 2013).
- 4.6. CBT and MET Therapies should occur simultaneous to the detoxification process and according to the member's readiness to change (ASAM Criteria, 2013).
- 4.7. Recovery support services designed to initiate, support and enhance recovery should be implemented alongside treatment services. This may include helping the member access a supportive living environment, participation in peer support services, and involvement in any wrap around services that may influence the member's treatment success (ASAM Criteria, 2013).
- 4.8. Peer support groups, including 12-step programs and other models, are a common component of treatment. Although there are differences among them, they commonly emphasize working toward abstinence through group sharing and support (Aronson, 2015).
- 4.9. Many members will experience Substance Use Disorder as chronic or recurrent. For this reason, evidence-based treatment models emphasize continuing care. Evidence suggests customizing treatment to individual needs and preferences, modifying the intensity of treatment with the waxing and waning of substance use over time, teaching members self-management skills, fostering linkages to other sources of support, and using data to measure and monitor clinical status (Aronson, 2015).

## **5. General Pharmacotherapy**

- 5.1. Pharmacotherapy as part of the member's treatment and recovery may be used to:
  - 5.1.1. Aid in withdrawal and/or to decrease the reinforcing effects of abused substances (opioid antagonists such as buprenorphine or naltrexone) and/or;
  - 5.1.2. Treat co-occurring medical and/or psychiatric conditions (according to symptoms and diagnosis)

- 5.2. Specific attention should be given to the medication evaluation and management of members with active psychiatric and/or medical symptoms. Assessment of the risks involved with medication use and choice of medication during pregnancy should be weighed (APA Guideline Watch, 2007).
- 5.3. Maintenance medication therapies and medications for the treatment of co-occurring psychiatric conditions may be administered and monitored within inpatient, residential, PHP and IOP levels of care when indicated (SAMHSA TIP 31, 2011).
- 5.4. Medication Assisted Treatment (MAT) or Medication Assisted Recovery (MAR) approaches may involve pharmacotherapy to support recovery and treatment interventions (ASAM Criteria, 2013).
- 5.5. Programs/providers should have direct access to pharmacotherapy treatment that may include medications to promote abstinence and/or medications to treat co-occurring medical or psychiatric conditions (ASAM Criteria, 2013).
- 5.6. Drug interactions, overdose, and changes in treatment engagement are clinically significant areas that require ongoing assessment when treating members with co-occurring psychiatric and substance use disorders (APA Guideline, 2006)

## **6. Withdrawal Management/Detoxification Medications**

- 6.1. Withdrawal management/detoxification medications are used to treat intoxication and withdrawal.
- 6.2. When managing intoxication, consider the following (APA Guideline, 2006):
  - 6.2.1. The substances used, route of administration, the dose, the time since the last dose, and whether the level of intoxication is waxing or waning all needs to be ascertained. When multiple substances have been used, the effects of each substance should be considered.
  - 6.2.2. The removal of substances from the body via gastric lavage or techniques that increase the excretion rate of substances or their active metabolites may be chosen.
  - 6.2.3. Medications that antagonize the actions of the abused substances may be used to reverse their effect. Examples include the administration of naloxone to members who have overdosed with heroin or other opioids or flumazenil to members who have overdosed on benzodiazepines.
  - 6.2.4. Intubations to decrease aspiration or medications to support blood pressure are approaches that can be used to stabilize the physical effects of an overdose.

- 6.3. When managing withdrawal, consider the following (APA Guideline, 2006):
- 6.3.1. Physically dependent individuals who discontinue their substance use after heavy or prolonged use may need to be monitored for withdrawal syndromes.
  - 6.3.2. Consider factors that may influence severity of withdrawal (type of substance used and rate of metabolism or co-occurring conditions).
  - 6.3.3. Replace the abused drug with a drug in the same or similar class with a longer duration of action and taper the longer-acting drug.
  - 6.3.4. Treat with medications to ameliorate withdrawal symptoms such as clonidine for opioid withdrawal or benzodiazepines or anticonvulsants for alcohol withdrawal.
- 6.4. Specific attention should be given to the medication evaluation and management of members with active psychiatric and/or medical symptoms (ASAM Criteria, 2013).
- 6.5. Medications to treat co-occurring medical and/or psychiatric conditions may be chosen with close monitoring of possible interactions during the detoxification process.

## **7. Managing Relapse**

- 7.1. The factors and precipitating events that triggered the member's relapse should be determined.
- 7.2. It should also be determined if there was a relapse prevention plan in place and whether the plan was implemented prior to the member's relapse.
- 7.3. Prior to developing or updating a relapse prevention plan, the provider should reassess the member's motivation and level of readiness to change.
- 7.4. The provider should develop a plan to how he/she will respond to member relapse. The following should be considered (Substance Abuse and Mental Health Service Administration. Medication-Assisted Treatment for Opioid Addiction, Treatment Improvement Protocol, 43 (SAMHSA TIP 43), 2009):
  - 7.4.1. A relapse indicates a reduction in overall stability of the member and may require an adjustment to the treatment plan or level of care.
  - 7.4.2. A reassessment of the intensity and effectiveness of psychosocial interventions may be needed, and if not currently in place, the need to introduce interventions.
  - 7.4.3. Beginning or increasing urine screening appointments.
  - 7.4.4. Ensuring that medical and behavioral conditions are stable.

- 7.4.5. Consider referrals for detoxification in addition to motivational enhancement and additional psychosocial interventions.
- 7.4.6. The provider and member should collaborate to devise a treatment plan which incorporates psychosocial interventions that support recovery and, where applicable, address treatment of co-occurring mental health conditions.

## **8. Discharge Planning**

- 8.1. The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- 8.2. The provider and, whenever possible, the member updates the initial discharge plan during the admission ensuring that:
  - 8.2.1. An appropriate discharge plan is in place prior to discharge;
  - 8.2.2. The discharge plan is designed to mitigate the risk that the “why now” factors which precipitated admission will reoccur;
  - 8.2.3. The member agrees with the discharge plan.
- 8.3. For members continuing treatment, the discharge plan includes:
  - 8.3.1. The discharge date;
  - 8.3.2. The post-discharge level of care, and the recommended forms and frequency of treatment;
  - 8.3.3. The names of the providers who will deliver treatment;
  - 8.3.4. The date of the first appointment including the date of the first medication management visit;
  - 8.3.5. The name, dose and frequency of each medication;
  - 8.3.6. A prescription sufficient to last until the first medication management visit is provided;
  - 8.3.7. An appointment for necessary lab tests is provided;
  - 8.3.8. Resources to assist the member with overcoming barriers to care such as lack of transportation or child care;
  - 8.3.9. Recommended self-help and community support services;
  - 8.3.10. Information about what the member should do in the event of a crisis prior to the first appointment.
  - 8.3.11. The first treatment appointment and medication management visit are scheduled to occur within a timeframe that is commensurate with the risk that the “why now” factors which led to admission will reoccur.

- 8.3.12. The provider shares the discharge plan and all pertinent clinical information with the providers at the next level of care prior to discharge.
  - 8.3.13. The provider shares the discharge plan and all pertinent clinical information with the Care Advocate to ensure that necessary prior authorizations or notifications are completed prior to discharge.
  - 8.3.14. Notification of the Care Advocate that the member is discontinuing treatment may trigger outreach and assistance to the member.
  - 8.3.15. The provider coordinates discharge with agencies and programs such as the school or court system with which the member is involved.
- 8.4. For members not continuing treatment, the discharge plan includes:
- 8.4.1. The discharge date;
  - 8.4.2. Recommended self-help and community support services;
  - 8.4.3. Information about what the member should do in the event of a crisis or to resume services.
  - 8.4.4. The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

<b>PART III: LEVEL OF CARE CRITERIA</b>
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**Common Criteria for All Levels of Care**

**1. Admission Criteria**

1.1. The member is eligible for benefits.

AND

1.2. The member's condition and proposed services are covered by the benefit plan.

AND

1.3. Services are within the scope of the provider's professional training and licensure.

AND

1.4. The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission).

1.4.1. Failure of treatment in a less intensive level of care is not a prerequisite for authorizing coverage.

AND

1.5. The member's current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. Assessment and/or treatment of acute changes in the member's signs and symptoms and/or psychosocial and environmental factors (i.e., the "why now" factors leading to admission) require the intensity of services provided in the proposed level of care.

AND

1.6. Co-occurring behavioral health and medical conditions can be safely managed.

AND

1.7. Services are:

1.7.1. Consistent with generally accepted standards of clinical practice;

1.7.2. Consistent with services backed by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;

1.7.3. Consistent with Optum's best practice guidelines;

1.7.4. Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.

AND

1.8. There is a reasonable expectation that services will improve the member's presenting problems within a reasonable period of time.

1.8.1. Improvement of the member's condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care.

1.8.2. Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member's signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member's recovery, resiliency and wellbeing.

AND

1.9. Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.

## **2. Continued Service Criteria**

- 2.1. The admission criteria continue to be met and active treatment is being provided. For treatment to be considered “active” services must be:
  - 2.1.1. Supervised and evaluated by the admitting provider;
  - 2.1.2. Provided under an individualized treatment plan that is focused on addressing the “why now” factors, and makes use of clinical best practices;
  - 2.1.3. Reasonably expected to improve the member’s presenting problems within a reasonable period of time.

AND

- 2.2. The “why now” factors leading to admission have been identified and are integrated into the treatment and discharge plans.

AND

- 2.3. Clinical best practices are being provided with sufficient intensity to address the member’s treatment needs.

AND

- 2.4. The member’s family and other natural resources are engaged to participate in the member’s treatment as clinically indicated.

## **3. Discharge Criteria**

- 3.1. The continued stay criteria are no longer met. Examples include:
  - 3.1.1. The “why now” factors which led to admission have been addressed to the extent that the member can be safely transitioned to a less intensive level of care, or no longer requires care.
  - 3.1.2. The “why now” factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.
  - 3.1.3. Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
  - 3.1.4. The member requires medical-surgical treatment.
  - 3.1.5. The member is unwilling or unable to participate in treatment and involuntary treatment or guardianship is not being pursued.

## **Detoxification, Inpatient**

### **Substance-Related Disorders**

**A hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, and active behavioral health treatment services for the purpose of completing a medically safe withdrawal from alcohol or drugs. Inpatient Detoxification is typically indicated when the “why now” factors that precipitated admission indicate that the member is at risk of severe withdrawal symptoms or serious medical complications stemming from withdrawal such as seizures, and requires detoxification in a safe and stable living environment that provides the intensity of nursing care and monitoring offered in Inpatient Detoxification.**

**The course of treatment in Inpatient Detoxification is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively conducted.**

#### **1. Admission Criteria**

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The “why now” factors leading to admission suggest that there is imminent or current risk of severe withdrawal with or without serious medical complications. Examples include:

1.2.1. The Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-AR) score is at least 19.

1.2.2. The member has a history of withdrawal seizures.

#### **2. Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

- 2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

### **3. Discharge Criteria**

- 3.1. (See Common Criteria for All Levels of Care)

#### **Detoxification, Outpatient**

##### **Substance-Related Disorders**

**Outpatient Detoxification is comprised of services that are provided in an ambulatory setting for the purpose of completing a medically safe withdrawal from alcohol or drugs. Outpatient Detoxification is typically indicated when the “why now” factors that precipitated admission indicate that there is little risk of moderate or severe withdrawal and co-occurring mental health and/or medical conditions – if present – can be safely managed in an ambulatory setting.**

**The course of treatment in Outpatient Detoxification is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively conducted.**

**Outpatient Detoxification is distinct from Office-Based Opioid Treatment and Opioid Treatment Programs.**

#### **1. Admission Criteria**

- 1.1. (See Common Criteria for All Levels of Care)

AND

- 1.2. The member is not in imminent or current risk of harm to self or others, and/or property.

AND

- 1.3. The “why now” factors leading to admission suggest that there is imminent or current risk of mild withdrawal. Medical complications, if present, can be safely managed. Examples include:

- 1.3.1. The Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-AR) score is less than 10.
- 1.3.2. Withdrawal can be effectively, efficiently, and safely managed without the intensity of nursing care, medical monitoring, and physician availability provided in Inpatient or Residential Detoxification.

#### **2. Continued Service Criteria**

- 2.1. (See Common Criteria for All Levels of Care)

### **3. Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

### **4. Clinical Best Practices**

#### **4.1. Evaluation & Treatment Planning**

- 4.1.1. (See Common Clinical Best Practices for All Levels of Care)
- 4.1.2. The psychiatrist or addictionologist in conjunction with the treatment team completes the initial evaluation commensurate with the member's needs, no later than 24 hours following admission.
- 4.1.3. During admission, the psychiatrist or addictionologist in conjunction with the treatment team monitors the progress of detoxification daily, evaluates the treatment program to determine the extent to which treatment goals are being realized, and changes the treatment plan as needed.
- 4.1.4. A psychiatrist or addictionologist is available to consult with the program during and after normal business hours.
- 4.1.5. Access to laboratory and toxicology testing is available.
- 4.1.6. Access to 24-hour emergency medical consultation is available.

#### **4.2. Discharge Planning**

- 4.2.1. (See Common Clinical Best Practices for All Levels of Care)

## **Detoxification, Residential**

### **Substance-Related Disorders**

**A sub-acute facility-based program which provides 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment services for the purpose of completing a medically safe withdrawal from alcohol or drugs. Residential Detoxification is typically indicated when the “why now” factors that precipitated admission indicate that the member requires detoxification in a safe and stable living environment, but does not require the intensity of nursing care, medical monitoring and physician availability offered in Inpatient Detoxification.**

**The course of treatment in Residential Detoxification is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively conducted.**

### **1. Admission Criteria**

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The “why now” factors leading to admission suggest that there is imminent or current risk of moderate withdrawal. Medical complications, if present, can be safely managed. Examples include:

1.2.1. The Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-AR) score is 10 to 18.

1.2.2. Withdrawal can be effectively, efficiently, and safely managed without the intensity of nursing care, medical monitoring, and physician availability provided in Inpatient Detoxification.

## **2. Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

## **3. Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

### **Intensive Outpatient Program**

#### **Substance-Related Disorders**

**A structured program that maintains hours of service generally 9-19 hours per week for adults and generally 6-19 hours per week for children/adolescents during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. Intensive Outpatient Program is appropriate for members who live in a community without the restrictions of a 24-hour supervised treatment setting during non-program hours.**

**The purpose of services is to monitor and maintain stability, decrease moderate signs and symptoms, increase functioning, help members integrate into community life, and help the member gain knowledge,**

**practice skills, and make changes in behavior that support recovery while living in his/her natural environment (i.e., home or other place of residence).**

**The course of treatment in an Intensive Outpatient Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.**

**An Intensive Outpatient Program can be used to treat substance-related disorders or can specialize in the treatment of co-occurring mental health and substance-related disorders.**

**When supported by the benefit plan, coverage may be available for Intensive Outpatient Program services that are coupled with overnight housing.**

## **1. Admission Criteria**

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.

AND

1.4. Assessment and diagnosis and/or treatment planning requires several days per week of structured observation and interaction provided in a program that generally maintains hours of service 9-19 hours per week for adults and 6-19 hours per week for children/adolescents. Examples include:

1.4.1. Assessment requires frequent interaction with the member and observation of the member with others.

1.4.2. The treatment plan must be frequently changed which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.5. The member requires engagement and support through structured interaction several days per week with the member in a program that generally maintains hours of service 9-19 hours per week for adults and 6-19 hours per week for children/adolescents. Examples include:

- 1.5.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center.
- 1.5.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

- 1.6. The member requires a structured environment several days per week in a program that generally maintains hours of service 9-19 hours per week for adults and 6-19 hours per week for children/adolescents providing an opportunity to practice and enhance skills both in the treatment environment and in the member's real world environment. Examples of skills include those that help the member:
  - 1.6.1. Maintain their current living situation;
  - 1.6.2. Return to work or school.

OR

- 1.7. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a program that generally maintains hours of service 9-19 hours per week for adults and 6-19 hours per week for children/adolescents. Examples of assistance include:
  - 1.7.1. Assistance with developing the skills needed to self-manage medications.
  - 1.7.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

**Criteria for Overnight Housing Coupled with an Intensive Outpatient Program**

- 1.8. Overnight housing is covered by the benefit plan.

AND

- 1.9. The treatment setting is separate from the housing.

AND

- 1.10. An unsupportive or high-risk living situation is undermining the member's recovery.

OR

- 1.11. Routine attendance at the Intensive Outpatient Program is hindered by the lack of transportation.

**2. Continued Service Criteria**

- 2.1. (See Common Criteria for All Levels of Care)

**3. Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

## **Outpatient**

### **Substance-Related Disorders**

**Assessment and diagnosis and active behavioral health treatment that are provided in an ambulatory setting. The course of treatment in Outpatient is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the “why now” factors that precipitated admission no longer require treatment.**

#### **1. Admission Criteria**

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk of harm to self, others, and/or property.

AND

1.3. There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.

AND

1.4. Acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors (i.e., the “why now” factors leading to admission) have occurred, and the member’s current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

#### **2. Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

#### **3. Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

## **Partial Hospital Program**

### **Substance-Related Disorders**

**A structured program that maintains hours of service for at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to members who are experiencing serious signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues. Partial Hospital Program is appropriate for members who live in a community without the restrictions of a 24-hour supervised treatment setting during non-program**

hours.

The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and help the member gain knowledge, practice skills, and make changes in behavior that support recovery while living in his/her natural environment (i.e., home or other place of residence).

The course of treatment in a Partial Hospital Program is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that the member’s condition can be safely, efficiently and effectively treated in a less intensive level of care.

A Partial Hospital Program can be used to treat mental health conditions or can specialize in the treatment of co-occurring mental health and substance-related disorders.

When supported by the benefit plan, coverage may be available for Partial Hospital Program services that are coupled with overnight housing.

## 1. Admission Criteria

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. The member is not in imminent or current risk or harm to self, others, and/or property.

AND

1.3. There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.

AND

1.4. Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include:

1.4.1. Assessment requires frequent interaction with the member, and observation of the member with others.

1.4.2. The treatment plan must be changed frequently which requires that the provider have face-to-face interactions with the member several times a week.

OR

1.5. The member requires engagement and support which requires extended interaction between the member and the program. Examples include:

- 1.5.1. The member requires a coordinated transition back into the community after treatment in Inpatient or a Residential Treatment Center, such as engagement with wraparound services or natural resources.
- 1.5.2. The member has been unable to access or utilize family or other natural resources on their own.

OR

1.6. The member requires a structured environment to practice and enhance skills. This requires face-to-face interactions several times a week that cannot be provided in a less intensive setting. Examples of skills include those that help the member:

- 1.6.1. Maintain their current living situation;
- 1.6.2. Return to work or school.

OR

1.7. The member requires a structured environment to complete goals and develop a plan for post-discharge services in a less intensive setting. Examples of assistance include:

- 1.7.1.1. Assistance with developing the skills needed to self-manage medications.
- 1.7.1.2. Assistance with making progress toward goals in spite of an environment that does not support recovery and/or limited community support services.

### **Criteria for Overnight Housing Coupled with a Partial Hospital Program**

1.8. Overnight housing is covered by the benefit plan.

AND

1.9. The treatment setting is separate from the housing.

AND

1.10. An unsupportive or high-risk living situation is undermining the member's recovery.

OR

1.11. Routine attendance at the Partial Hospital Program is hindered by the lack of transportation.

## **2. Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

## **3. Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

## **Rehabilitation, Inpatient**

### **Substance-Related Disorders**

**A hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, and active behavioral health treatment services for the purpose of initiating the process of assisting a member with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder. The “why now” factors that precipitated admission indicate that the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning requires that rehabilitation be initiated in a safe and stable living environment.**

**The course of treatment in Inpatient Rehabilitation is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively continued in a less intensive level of care.**

#### **1. Admission Criteria**

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.

AND

1.3. The “why now” factors leading to admission and/or the member’s history of response to treatment suggest that there is imminent or current risk of relapse which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

- 1.3.1. A co-occurring mental health condition has worsened and the member’s behavior has become more impulsive.
- 1.3.2. The member has resumed using alcohol or drugs, and the history of treatment suggests that the structure and support provided in this level of care is needed to control the recurrence.

OR

1.4. The “why now” factors leading to admission suggest that the member’s condition cannot be safely, efficiently, and effectively treated in a less intensive setting due to a physical complication. Examples include:

- 1.4.1. Alcohol or drug use has caused a medical complication that can be safely managed in this setting.

1.4.2. A severe medication side effect requires the level of monitoring and intervention available in Inpatient Rehabilitation.

OR

1.5. The “why now” factors leading to admission cannot be safely, effectively, and efficiently addressed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:

1.5.1. Acute impairment of behavior or cognition is interfering with Activities of Daily Living to the extent that the welfare of the member or others is endangered.

1.5.2. Psychosocial and environmental problems threaten the member’s safety, or undermine engagement in a less intensive level of care.

OR

1.6. The “why now” factors which led to admission to Crisis Stabilization & Assessment or 23-Hour Observation could not be addressed, and the member must be admitted to Inpatient Rehabilitation.

## **2. Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

AND

2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:

2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).

2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

## **3. Discharge Criteria**

3.1. (See Common Criteria for All Levels of Care)

### **Rehabilitation, Residential**

#### **Substance-Related Disorders**

**A sub-acute facility-based program which provides 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment services to members who do not require the intensity of nursing**

**care, medical monitoring, and physician availability offered in Inpatient Rehabilitation for the purpose of initiating the process of assisting a member with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.**

**The course of treatment in Residential Rehabilitation is focused on addressing the “why now” factors that precipitated admission (e.g., changes in the member’s signs and symptoms, psychosocial and environmental factors, or level of functioning) to the point that rehabilitation can be safely, efficiently and effectively continued in a less intensive level of care.**

## **1. Admission Criteria**

1.1. (See Common Criteria for All Levels of Care)

AND

1.2. There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.

AND

1.3. The “why now” factors leading to admission and/or the member’s history of response to treatment suggest that there is imminent or current risk of relapse which cannot be safely, efficiently, and effectively managed in a less intensive level of care. Examples include:

1.3.1. A co-occurring mental health condition is stabilizing but the remaining signs and symptoms are likely to undermine treatment in a less intensive setting.

1.3.2. The member is in immediate or imminent danger of relapse, and the history of treatment suggests that the structure and support provided in this level of care is needed to control the recurrence.

AND

1.4. The “why now” factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the member’s signs and symptoms, and/or psychosocial and environmental factors. Examples include:

1.4.1. Acute impairment of behavior or cognition is interfering with Activities of Daily Living to the extent that the welfare of the member or others is endangered.

1.4.2. Psychosocial and environmental problems threaten the member’s safety, or undermine engagement in a less intensive level of care.

## **2. Continued Service Criteria**

2.1. (See Common Criteria for All Levels of Care)

AND

- 2.2. Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
- 2.2.1. Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring and ambulating).
  - 2.2.2. Health-related services that are provided for the primary purpose of meeting the personal needs of the member or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
  - 2.2.3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

### **3. Discharge Criteria**

- 3.1. (See Common Criteria for All Levels of Care)

## **PART IV: ADDITIONAL RESOURCES**

### **Clinical Protocols**

Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on ubhonline

### **Peer Review**

Optum will offer a peer review to the provider when services do not appear to conform to this guideline. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis

### **Second Opinion Evaluations**

Optum facilitates obtaining a second opinion evaluation when requested by an enrollee, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

### **Referral Assistance**

Optum provides assistance with accessing care when the provider and/or enrollee determine that there is not an appropriate match with the enrollee's clinical needs and goals, or if additional providers should be involved in delivering treatment.

## **PART V: DEFINITIONS**

**CIWA Scale** The Clinical Institute Withdrawal Assessment is an assessment tool used for monitoring withdrawal symptoms from alcohol. The assessment takes approximately 5 minutes to administer. The maximum score is 67 and patients scoring less than 10 do not typically need additional medication for withdrawal.

**Cognitive Behavioral Therapy (CBT)** A classification of therapies that are predicated on the idea that behavior and feelings are caused by thoughts.

**Detoxification (aka, Withdrawal Management)** The metabolic process by which the toxic qualities of a poison or toxin are reduced by the body. Pertaining to addiction it is generally a medically supervised treatment for alcohol or drug addiction designed to purge the body of intoxicating or addictive substances. Such a program is used as a first step in overcoming physiological or psychological addiction.

**Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)** A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and Substance-Related Disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

**Dual Diagnosis** Refers to the patient who has signs and symptoms of concurrent substance-related and mental disorders. Co-occurring disorders is another term that is often used interchangeably.

**Inpatient Rehabilitation** Inpatient rehabilitation units provide 24-hour, intense, structured, monitored services that include: observation, medical monitoring, and addiction treatment in an inpatient setting. They are appropriate for members whose biomedical and behavioral problems are so severe that they require inpatient treatment that is delivered concurrently with addiction treatment, but do not require inpatient detoxification or 24-hour medical supervision and management.

**Inpatient Detoxification** Inpatient detoxification is comprised of services that are provided in an acute care hospital for the purpose of completing a medically safe withdrawal from alcohol or drugs. Inpatient detoxification is typically indicated when there is a risk of severe withdrawal symptoms or seizures, and/or co-occurring medical or mental health conditions that cannot be safely managed in a less intensive detoxification setting.

**Intensive Outpatient Program** Intensive Outpatient Program (IOP) is a freestanding or hospital-based program that maintains hours of service for at least 6 hours per week. It may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospital/day treatment program.

**Motivational Enhancement Therapy (MET)** A patient-centered counseling approach for initiating behavior change by helping patients to resolve ambivalence about engaging in treatment and stopping substance use. This approach employs strategies to evoke rapid and internally motivated change in the patient, rather than guiding the patient stepwise through the recovery process.

**Outpatient** Visits provided in an ambulatory setting.

**Partial Hospital/Day Treatment Program** A freestanding or hospital-based program that maintains hours of service for at least 20 hours per week, and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care, or as a step down from a more intensive level of care.

**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.

**Residential Detoxification** Residential detoxification is comprised of services that are provided in a residential setting other than an acute care hospital for the purpose of completing a medically safe withdrawal from alcohol or drugs. Residential detoxification is typically indicated when withdrawal is severe enough to warrant 24-hour care, but on-site access to medical personnel is not essential.

**Residential Rehabilitation** Residential rehabilitation is comprised of acute overnight services that are typically provided in a freestanding Residential Treatment Center for the care of a Substance-Related Disorders.

**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.

**Substance-Related Disorders** A cluster of cognitive, behavioral, and physiological symptoms indicated that the individual continues using the substance despite significant substance related problems. The diagnosis is based on a pathological pattern of behaviors related to the use of any of the 10 classes of drugs identified in the DSM.

**Withdrawal** Consists of a predictable group of signs and symptoms resulting from abrupt removal of, or a rapid decrease in, the regular dosage of a psychoactive substance. The syndrome is often characterized by over activity of the physiological functions that were suppressed by the drug and/or depression of the functions that were stimulated by the drug.

**Withdrawal Symptoms** Withdrawal from opioids or alcohol can be severe and excruciating. Withdrawal generally begins between 4 to 72 hours after the last use (depending on the extent of use), The symptoms are both physical and emotional and include: dilated pupils, goose bumps, watery eyes, runny nose, yawning, loss of appetite, tremors, panic, chills, nausea, dry heaves, muscle cramps, insomnia, stomach cramps, diarrhea, vomiting, shaking, chills or profuse sweating, irritability, jitters, and increased sensitivity to pain.

## **PART VI: REFERENCES**

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## PART VII: CODING

*The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.*

Limited to specific CPT and HCPCS codes?	X Yes <input type="checkbox"/> No
90791	Psychiatric diagnostic evaluation
90791 plus interactive add-on code (90785)	Psychiatric diagnostic evaluation (interactive)
90832	Psychotherapy, 30 minutes with patient and/or family
90832 plus interactive add-on code (90785)	Psychotherapy, 30 minutes with patient and/or family (interactive)
90832 plus pharmacological add-on code (90863)	Psychotherapy, 30 minutes with patient and/or family (pharmacological management)
90834	Psychotherapy, 45 minutes with patient and/or family member
90834 plus interactive add-on code (90785)	Psychotherapy, 45 minutes with patient and/or family member (interactive)
90834 plus pharmacological add-on code (90863)	Psychotherapy, 45 minutes with patient and/or family member (pharmacological management)
90837	Psychotherapy, 60 minutes with patient and/or family member

90837 plus interactive add-on code (90785)	Psychotherapy, 60 minutes with patient and/or family member (interactive)
90837 plus pharmacological add-on code (90863)	Psychotherapy, 60 minutes with patient and/or family member (pharmacological management)
90839	Psychotherapy for crisis, first 60 minutes
90839 plus interactive add-on code (90785)	Psychotherapy for crisis, first 60 minutes (interactive)
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)
90853 plus interactive add-on code (90785)	Group psychotherapy (other than of a multiple-family group) (interactive)
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
H0015	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 therapy
H0035	Mental health partial hospitalization, treatment, less than 24 hours
S0201	Partial hospitalization services, less than 24
S9480	Intensive outpatient psychiatric services, per die

Limited to specific diagnosis codes?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
305.00; 303.90; 303.90	Alcohol Use Disorder (mild, moderate, severe)
303.00	Alcohol Intoxication
291.81	Alcohol Withdrawal
305.90	Caffeine Intoxication
292.0	Caffeine Withdrawal
305.2; 304.3; 304.3	Cannabis Use Disorder (mild, moderate, severe)
292.89	Cannabis Intoxication
292.0	Cannabis Withdrawal
305.90; 304.60; 304.60	Phencyclidine Use Disorder (mild, moderate, severe)
305.30; 304.50; 304.50	Other Hallucinogen Use Disorder (mild, moderate, severe)
292.89	Phencyclidine Intoxication
292.89	Other Hallucinogen Intoxication
292.89	Hallucinogen Persisting Perception Disorder
305.90; 304.60; 304.60	Inhalant Use Disorder (mild, moderate, severe)
292.89	Inhalant Intoxication
305.50; 304.00; 304.00	Opioid Use Disorder (mild, moderate, severe)

292.89	Opioid Intoxication
292.0	Opioid Withdrawal
305.40; 304.10; 304.10	Sedative, Hypnotic, or Anxiolytic Use Disorder (mild, moderate, severe)
292.89	Sedative, Hypnotic, or Anxiolytic Intoxication
292.0	Sedative, Hypnotic, or Anxiolytic Withdrawal
305.70; 305.60; 305.70 (mild); 304.40; 304.20; 304.40 (moderate); 304.40; 304.20; 304.40 (severe)	Stimulant Use Disorder (amphetamine; cocaine; other stimulant)
292.89	Stimulant Intoxication
292.0	Stimulant Withdrawal
305.1; 305.1; 305.1	Tobacco Use Disorder
292.0	Tobacco Withdrawal

<b>Limited to place of service (POS)?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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<b>Limited to specific provider type?</b>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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<b>Limited to specific revenue codes?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
100-160	(Range describes various all-inclusive inpatient services)
900-919	(Range describes various unbundled behavioral health treatments/services)
1000-1005	(Range describes various sites that provider 24-hour services)

## **PART VIII: HISTORY**

<b>Revision Date</b>	<b>Name</b>	<b>Revision Notes</b>
9/2010	L. Urban	Version 1-Final
1/2012	L. Urban	Version 2-Final
3/2013	J. Niewenhous	Version 3-Final
4/2014	L. Urban	Version 4-Final
10/2014	L. Urban	Version 5-Final
6/2015	L. Urban	Version 6-Final
11/2015	J. Niewenhous	Version 7-Final
11/2015	J. Niewenhous	Version 8-Final