

Alcohol and Substance Abuse Treatment Medicare Coverage Summary

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**Centers for Medicare and Medicaid Local
Coverage Determinations:**

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INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum for Medicare enrollees.

The enrollee's specific Evidence of Coverage (EOC)/Summary of Benefits (SB) must be referenced for specific plan provisions for coverage, limitations, and exclusions. In the event of a conflict between these guidelines and the enrollee's EOC/SB, the enrollee's specific EOC/SB will supersede these guidelines.

All reviewers must first identify enrollee eligibility, any federal or State regulatory requirements, and the enrollee's EOC/SB plan prior to use of this guideline.

The information provided is intended only as a guideline and will not address every aspect or clinical situation.

In the event that there is no available guideline for a particular State, jurisdiction, condition or service, the Optum Level of Care Guidelines should be used for medical necessity decisions along with the enrollee's applicable EOC/SB.

Optum reserves the right, in its sole discretion, to modify its clinical guidelines as necessary, and to update this coverage determination guideline in accordance with updates to CMS National and Local Coverage Determinations. While this Coverage Determination Guideline does reflect Optum's understanding of current best practices in care, it does not constitute medical advice.

Key Points

- This guideline is based on the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations (NCDs/LCDs) active at the time this guideline was written. The intent of this document is to summarize the coverage criteria and best practices for the delivery of Alcohol, Chemical and/or Substance Abuse Detoxification and Rehabilitation services as they apply to Medicare members.
- Behavioral Health care services or supplies should be provided when reasonable and necessary to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine (Medicare.gov, Glossary, 2016). Benefits are available for covered services that are not otherwise limited or excluded. The benefit information in this document is based on active CMS NCDs/LCDs that may be updated with new or more current information since the time this document was written.
- This is a National Coverage Summary applicable to all States/jurisdictions at the time this guideline was written. This document summarizes the following National Coverage Determinations (Medicare National Coverage Determinations Manual (NCD Manual), Chapter 1, Part 2, Section 90-130, 2015):
 - Inpatient Hospital Stays for Treatment of Alcoholism – Detoxification and Rehabilitation (130.1)
 - Outpatient Hospital Services for Treatment of Alcoholism (130.2)
 - Chemical Aversion Therapy for Treatment of Alcoholism (130.3)
 - Electrical Aversion Therapy for Treatment of Alcoholism (130.4)
 - Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic (130.5)
 - Treatment of Drug Abuse (Chemical Dependency) (130.6)
 - Withdrawal Treatments for Narcotic Addictions (130.7)
- CMS recognizes there are similarities between the treatment for drug abuse and alcohol abuse. The intensity and duration of treatment may vary depending on the substance used, duration of use, and the member's condition (CMS NCD Manual, Section 130.6). Accordingly, coverage is available for the treatment of both alcohol and substance abuse when the medical necessity for each service is met according to the criteria below.

PART I: BENEFITS

Before using this guideline, please check enrollee's specific Evidence of Coverage (EOC)/Summary of Benefits (SB) and any federal or state mandates, if applicable.

Benefits

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Psychotherapy
- Crisis intervention

Behavioral Health care services or supplies are provided when needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine (Medicare.gov, Glossary, 2016).

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 Evidence of Coverage/Summary of Benefits. When the requested service or procedure is limited or excluded from the enrollee's EOC, or is otherwise defined differently, it is the terms of the enrollee's EOC/SB that prevails.

Additional Information

The lack of a specific exclusion for coverage for a service does not imply that the service is covered.

No payment can be made for certain items and services, when the following conditions exist (CMS Benefit Policy Manual, 2016):

- Not reasonable and necessary: Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve functioning are not covered.
- Custodial care: Personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, the intermediary or carrier considers the level of care and medical supervision required and furnished. It does not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.
- Excluded Investigational Devices or Procedures: These items and procedures include any procedure, study, test, drug, equipment or facility still undergoing study and which is generally not accepted as standard therapy in the medical community where alternative therapy exists.

The following are examples of services that are limited or excluded. The following list may not be all-inclusive (CMS NCDs, 2016):

- The following providers are not eligible to enroll in Medicare or provide substance abuse services to Medicare members (Medicare Program Manual, Section 15.4.8):
 - Certified Alcohol and Drug Counselor
 - Drug and Alcohol Rehabilitation Counselor
 - Licensed Alcoholic and Drug Counselor
 - Free Standing Substance Abuse Facility
- Electrical Aversion Therapy, Electro-Shock Therapy, Noxious Faradic Stimulation for the treatment of alcoholism are not considered safe and effective and excluded from coverage (CMS NCD Manual, Section 130.4)
- Outpatient Services for the treatment of substance use does not include coverage for meals, transportation, activity therapies, group activities or services that are primarily recreational or diversional in nature (CMS Benefit Policy Manual, 2016).
- The following do not represent reasonable and necessary inpatient services for the treatment of substance use and coverage is excluded for (CMS Inpatient LCDs, 2016):
 - Inpatient services not appropriately certified by the physician
 - Services attempting to maintain psychiatric wellness for the chronically mentally ill
 - Treatment of chronic conditions without acute exacerbation
 - Vocational training
 - Medical records that fail to document the required level of physician supervision and treatment planning process
 - Electro sleep therapy
 - Hemodialysis for the treatment of schizophrenia
 - Transcendental Meditation
 - Multiple Electroconvulsive Therapy (MECT)
 - Patients who require primarily social, custodial, recreational, or respite care
 - Patients whose clinical acuity requires less than twenty-four (24) hours of supervised care per day
 - Patients who have met the criteria for discharge from inpatient hospitalization
 - Patients whose symptoms are the result of a medical condition that requires a medical/surgical setting for appropriate treatment

- Patients whose primary problem is a physical health problem without a concurrent major psychiatric episode
- Patients with alcohol or substance abuse problems who do not have a need for "active treatment" that can only be provided in the inpatient hospital setting
- Patients for whom admission to a hospital is being used as an alternative to incarceration

PART II: INITIAL COVERAGE CRITERIA

Inpatient Substance Abuse Treatment

1. Active Inpatient Treatment

- 1.1. Services provided in the hospital must be "active" as outlined in the CMS Benefit Policy Manual, Chapter 2, Section 30.2.3. To be designated as "active" services must be all of the following:
 - 1.1.1. Provided under an individualized treatment or diagnostic plan.
 - 1.1.2. Supervised and evaluated by a physician.
 - 1.1.3. Reasonably expected to improve the member's condition or for the purpose of diagnostic study.
 - 1.1.3.1. It is not necessary that a course of therapy have as its goal the restoration of the member to a level which would permit discharge from the institution although the treatment must, at a minimum, be designed both reduce or control the member's symptoms that necessitated hospitalization and improve the member's level of functioning.
 - 1.1.4. If the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the member's condition, or because intensive treatment services are not being furnished), program payment can no longer be made. When the period of "active treatment" ends, the physician is to indicate the end date (CMS Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, Section 10.9).

2. Inpatient Detoxification

Admission Criteria 2.1 AND 2.2 must be met:

- 2.1. The member is diagnosed with Substance-Related Disorder according to the DSM-5 and due to acute withdrawal symptoms, requires the intensity of active services that can only be provided in a 24-hour inpatient detoxification setting (CMS Benefit Policy Manual, Chapter 2-20). Examples include (ASAM Criteria, 2013):

- 2.1.1. The member is on a withdrawal/detoxification regimen or the response to a regimen requires monitoring or intervention more frequently than hourly.
- 2.1.2. The member needs withdrawal/detoxification management or stabilization while pregnant until able to be safely treated in a less intensive level of care.
- 2.1.3. The member has comorbid physical, emotional, behavioral, or cognitive condition that may increase in clinical severity at a lower level of care.

AND

2.2. There has been or there is a high probability of a medical complication during detoxification that the member requires the constant availability of physicians and/or complex medical equipment in a 24-hour hospital setting. Examples include the member experiencing (CMS NCD Manual, Section 130.1):

- 2.2.1. Delirium
- 2.2.2. Confusion
- 2.2.3. Seizure Disorder
- 2.2.4. Trauma
- 2.2.5. Unconsciousness

OR

2.3. For ***Combined Detoxification and Rehabilitation***, the member must meet criteria for both Inpatient Detoxification and Inpatient Rehabilitation (CMS NCD Manual, Section 130.1).

3. Inpatient Rehabilitation

Admission Criteria 3.1 OR 3.2 must be met:

- 3.1. The member is diagnosed with a Substance-Related Disorder according to the DSM-5 and due to chronic substance use, requires the intensity of active services that can only be provided in an inpatient rehabilitation setting (e.g., services provided by physicians and psychologists in a structured 24-hour hospital setting) and address severe co-occurring medical, emotional, behavioral, or cognitive problems (CMS NCD Manual, Section 130.1). Examples include (ASAM Criteria, 2013):
 - 3.1.1. The member is at risk of withdrawal but the member does not require intensive 24-hour medical monitoring.
 - 3.1.2. The member requires a 24-hour structure to provide concurrent treatment for a mental health condition.

- 3.1.3. The member has been unable to control use despite active participation in less intensive levels of care.
- 3.1.4. The member's environment is dangerous and the member lacks coping skills outside of a 24-hour setting.

OR

- 3.2. There is documentation by the physician that recent rehabilitation services in a less intensive setting or on an outpatient basis have proven unsuccessful and, as a consequence, the member requires the supervision and intensity of services which can only be found in the controlled environment of the hospital (CMS NCD Manual, Section 130.1)

OR

- 3.3. For ***Combined Detoxification and Rehabilitation***, the member must meet criteria for both Inpatient Detoxification and Inpatient Rehabilitation (CMS NCD Manual, Section 130.1).

4. Chemical Aversion Therapy

- 4.1. Chemical Aversion Therapy is a behavior modification technique that is used in the treatment of alcoholism. Chemical Aversion Therapy facilitates alcohol abstinence through the development of conditioned aversions to the taste, smell, and sight of alcohol. This is accomplished by repeatedly pairing alcohol with unpleasant symptoms induced by FDA approved chemical agents (CMS NCD Manual, Section 130).

All of the following must be met:

- 4.2. A physician must certify that Chemical Aversion Therapy is a reasonable and necessary service according to the member's individual circumstances (CMS NCD Manual).

AND

- 4.3. Chemical Aversion Therapy must be administered as part of a multi-modal treatment program that includes other behavioral techniques and psychotherapy (CMS NCD Manual).

AND

- 4.4. Treatment with Chemical Aversion Therapy is typically provided on an inpatient basis with follow-up treatments generally provided on an outpatient basis (CMS NCD Manual).
 - 4.4.1. The reasonableness and necessity of treatment and the need for inpatient hospitalization must be based on accepted medical practice, with the advice of a medical consultant and documented by a physician.

AND

- 4.5. Treatment with Chemical Aversion Therapy must be administered using an FDA approved agent. The FDA approved agent for Chemical Aversion Therapy is Disulfiram (Antabuse). (Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol 49, (SAMHSA), 2009).

Outpatient Substance Abuse Treatment

1. Outpatient

Both 1.1 AND 1.2 must be met:

- 1.1. The member has been discharged from an inpatient hospital stay for the treatment of a Substance-Related Disorder, or outpatient is the initial level of care for the member whose severity of illness and level of functioning require treatment to change substance abuse and addictive behaviors (e.g., pharmacotherapy, psychotherapy, and/or psychoeducation provided by physicians, psychologists, and nurses and). (CMS NCD Manual, Section 130.2; ASAM Criteria, 2013).

AND

- 1.2. Services must be for the purpose of diagnostic study or reasonably expected to improve the member's condition, and designed to reduce or control the member's symptoms, to prevent relapse or hospitalization, and improve or maintain the member's level of functioning (CMS Benefit Policy Manual, Chapter 6-20).

2. Outpatient Withdrawal

- 2.1. The member meets diagnostic criteria for Substance Withdrawal according to the DSM (CMS NCD Manual, 130.7).
- 2.2. Withdrawal treatment is provided directly by a physician or under the physician's personal supervision (CMS NCD Manual, 130.7).
- 2.3. The member qualifies for withdrawal treatment according to the following ASAM Criteria, Third Edition (2013):
 - 2.3.1. Level 1 – Withdrawal Management without extended onsite monitoring may be delivered in a physician's office or in a patient's home by trained clinicians who provide evaluation, withdrawal management and referral services.
 - 2.3.1.1. The member is experiencing at least mild signs and symptoms of withdrawal, or there is evidence that withdrawal management is imminent.

AND

- 2.3.1.2. The member has been assessed as being at minimal risk of severe withdrawal syndrome, can be safely managed at this level and is likely to enter into continued treatment or self-help recovery as evidenced by the following:
 - 2.3.1.2.1. The member has an adequate understanding of ambulatory withdrawal management and has expressed commitment to enter such a program.
 - 2.3.1.2.2. The member has adequate support services to ensure commitment to completion of withdrawal management and entry into ongoing treatment or recovery.
 - 2.3.1.2.3. The member is willing to accept a recommendation for treatment.

PART III: CONTINUED COVERAGE CRITERIA

1. Continued Stay Criteria for All Levels of Care

It may be appropriate to continue treatment at the present level of care if one or more of the following is met (ASAM Criteria, 2013):

- 1.1. The member is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.

OR

- 1.2. The member is not yet making progress, but has the capacity to resolve his or her problems. He or she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the member to continue to work toward his or her treatment goals.

AND/OR

- 1.3. New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay at the current level of care. The level of care in which the member is receiving treatment is therefore the least intensive at which the member's new problems can be addressed effectively.

PART IV: DISCHARGE CRITERIA

1. Discharge Criteria for All Levels of Care

It may be appropriate to transfer or discharge the member from the present level of care if he or she meets one or more of the following criteria (ASAM Criteria, 2013):

- 1.1. The member has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem that justified admission to the present level of care. Continuing the chronic disease management of the member's condition at a less intensive level of care is indicated.

OR

- 1.2. The member has been unable to resolve the problems that justified admission to the present level of care, despite amendments to the treatment plan. The member is determined to have achieved the maximum possible benefit from engagement in the services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of service, or discharge from treatment, is therefore indicated.

OR

- 1.3. The member has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problems. Treatment at a qualitatively different level of care or type of services, or discharge from treatment, is therefore indicated.

OR

- 1.4. The member has experienced an intensification of his or her problem, or has developed a new problem, and can be treated effectively only at a more intensive level of care.

PART V: CLINICAL BEST PRACTICE

1. Evaluation

- 1.1. 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:
 - 1.1.1. Acute intoxication and/or withdrawal potential exploring the individual's past and current experiences of substance use and withdrawal.
 - 1.1.2. Biomedical conditions and complications exploring health history and current physical condition.
 - 1.1.3. Emotional, behavioral or cognitive conditions or complications, exploring an individual's thoughts, emotions, and mental health issues.

- 1.1.4. Readiness to change exploring an individual's readiness and interest in changing.
 - 1.1.5. Relapse, continued use, or continued problem potential exploring an individual's unique relationship with relapse or continued use or problems.
 - 1.1.6. Recovery/Living environment exploring an individual's recovery or living situation, and the surrounding people, places and things.
- 1.2. Symptom screening that includes the use of screening tools and structured interviews may aid in evaluating the member's symptoms. 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:
- 1.2.1. The Drug Abuse Screening Test (DAST)
 - 1.2.2. The Addiction Severity Index (ASI)
 - 1.2.3. The Structured Clinical Interview (SCID)
 - 1.2.4. The Stages of Readiness and Treatment Eagerness Scale (SOCRATES)
 - 1.2.5. The Clinical Institute Withdrawal Assessment (CIWA-Ar) if applicable
 - 1.2.6. The Alcohol Use Disorders Identification Test (AUDIT) if applicable
 - 1.2.7. Clinical Opiate Withdrawal Scale (COWS), if applicable
 - 1.2.8. 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.
- 1.3. A physical examination and other necessary diagnostic evaluations should be completed to the extent possible and as indicated by the member's clinical presentation to rule out other causes of symptomatology (CMS LCD, 2016).
- 1.4. The results from the evaluation should determine the member's diagnosis, level of risk, treatment setting and treatment planning goals (ASAM Criteria, 2013).

2. Treatment Planning

- 2.1. The treatment plan is the tool used by the physician and multi-disciplinary treatment team to implement the physician-ordered services and move the patient toward the expected outcomes and goals (CMS Psychiatric Inpatient LCD, 2016).
- 2.2. The services must be provided in accordance with the diagnosis and treatment plan developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities (CMS Psychiatric Inpatient LCD, 2016).
- 2.3. This individualized, comprehensive, outcome-oriented plan of treatment should be developed (CMS Psychiatric Inpatient LCD, 2016):
 - 2.3.1. Within the first three (3) program days after admission for inpatient settings;
 - 2.3.2. By the physician, the multidisciplinary treatment team, and the patient; and
 - 2.3.3. Based upon the problems identified in the physician's diagnostic evaluation, psychosocial and nursing assessments.
- 2.4. The plan of treatment should include (CMS Psychiatric Inpatient LCD, 2016):
 - 2.4.1. The specific treatments ordered, including the type, amount, frequency, and duration of the services to be furnished;
 - 2.4.2. The expected outcome for each problem addressed; and
 - 2.4.3. Outcomes that are measurable, functional, time-framed, and directly related to the cause of the member's admission.
- 2.5. Treatment plan updates should show the treatment plan to be reflective of active treatment, as indicated by documentation of changes in the type, amount, frequency, and duration of the treatment services rendered as the patient moves toward expected outcomes (CMS Psychiatric Inpatient LCD, 2016).
- 2.6. Treatment plan updates should be documented at least weekly in inpatient settings or as the physician and treatment team assess the patient's current clinical status and make necessary changes. Lack of progress and its relationship to active treatment and reasonable expectation of improvement should also be noted (CMS Psychiatric Inpatient LCD, 2016).

3. Psychosocial Treatment Interventions

- 3.1. 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).
- 3.2. 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 (American Psychiatric Association, Practice Guideline for the Treatment of Substance Use Disorders (APA Guideline), 2006).
- 3.3. 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).
- 3.4. All MET interventions are based on the member's readiness to change according to the following stages (SAMHSA TIP 35, 2011):
 - 3.4.1. Precontemplation Stage interventions include:
 - 3.4.1.1. Establishing rapport, asking permission, and building trust to engage the member.
 - 3.4.1.2. Raising doubts or concerns in the member about substance-using patterns.
 - 3.4.1.3. Exploring the meaning of events that brought the member to treatment or the results of previous treatments.
 - 3.4.1.4. Eliciting the member's perceptions of the problem.
 - 3.4.1.5. Offering factual information about the risks of substance use and;
 - 3.4.1.6. Expressing concern and keeping the door open.
 - 3.4.2. Contemplation Stage interventions include:
 - 3.4.2.1. Normalizing ambivalence.

- 3.4.2.2. 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;
- 3.4.2.3. Eliciting self-motivational statements of intent and commitment from the member.
- 3.4.3. Preparation Stage interventions include:
 - 3.4.3.1. Clarifying the member's own goals and strategies for change.
 - 3.4.3.2. Offering a menu of options for change or treatment.
 - 3.4.3.3. With permission, offering expertise and advice.
 - 3.4.3.4. Negotiating a change and behavior contract.
 - 3.4.3.5. Considering and lowering barriers to change.
 - 3.4.3.6. Helping the member enlist social support.
 - 3.4.3.7. Exploring treatment expectations and the member's role.
 - 3.4.3.8. Eliciting from the member what has worked in the past.
 - 3.4.3.9. Assisting the member to negotiate finances, child care, work, transportation, or other potential barriers.
 - 3.4.3.10. Having the member publicly announce plans to change.
- 3.4.4. Action Stage interventions include:
 - 3.4.4.1. Engaging the member in treatment and reinforcing the importance of remaining in recovery.
 - 3.4.4.2. Supporting a realistic view of change through small steps.
 - 3.4.4.3. Acknowledging difficulties for the member in early stages of change.
 - 3.4.4.4. Helping the member identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these.
 - 3.4.4.5. Assisting the member in finding new reinforcers of positive change.
 - 3.4.4.6. Helping the member assess whether he or she has strong family and social support.
- 3.4.5. Maintenance Stage interventions include:

- 3.4.5.1. Helping the member identify and sample drug-free sources of pleasure (i.e., new reinforcers).
- 3.4.5.2. Supporting lifestyle changes.
- 3.4.5.3. Affirming the member's resolve and self-efficacy.
- 3.4.5.4. Helping the member practice and use new coping strategies to avoid a return to use.
- 3.4.5.5. Maintaining supportive contact (e.g., explain to the member that you are available to talk between sessions).
- 3.4.5.6. Developing a plan if the member resumes substance use or if the relapse prevention plan fails.
- 3.4.5.7. Reviewing long-term goals with the member.
- 3.4.6. Recurrence Stage interventions include:
 - 3.4.6.1. Helping the member reenter the change cycle and commending any willingness to reconsider positive change.
 - 3.4.6.2. Exploring the meaning and reality of the recurrence as a learning opportunity.
 - 3.4.6.3. Assisting the member in finding alternative coping strategies.
 - 3.4.6.4. Maintaining supportive contact.
- 3.4.7. Cognitive Behavioral Therapy (CBT) may also be implemented. 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).
- 3.4.8. CBT interventions for Substance Use Disorders typically combine traditional CBT methods with social skills training and relapse prevention methods.
- 3.4.9. Focused on a rewards approach, utilizing the member's interactions with family, employers, court system or random drug testing as measures of progress.
- 3.4.10. Members may be introduced to support groups, group therapy and other self-help methods in preparation for the next, most appropriate level of care.

- 3.4.11. 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).
- 3.4.12. 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).
- 3.4.13. CBT and MET Therapies should occur simultaneous to the detoxification process and according to the member's readiness to change (ASAM Criteria, 2013).
- 3.4.14. 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. General Pharmacotherapy

- 4.1. Pharmacotherapy as part of the member's treatment and recovery may be used to:
 - 4.1.1. Aid in withdrawal and/or to decrease the reinforcing effects of abused substances (opioid antagonists such as buprenorphine or naltrexone) and/or;
 - 4.1.2. Treat co-occurring medical and/or psychiatric conditions (according to symptoms and diagnosis)
- 4.2. Specific attention should be given to the medication evaluation and management of members with active psychiatric and/or medical symptoms (APA Guideline Watch, 2007).
- 4.3. Maintenance medication therapies and medications for the treatment of co-occurring psychiatric conditions may be administered and monitored within inpatient and outpatient levels of care when indicated (SAMHSA TIP 31, 2011).
- 4.4. Medication Assisted Treatment (MAT) or Medication Assisted Recovery (MAR) approaches may involve pharmacotherapy to support recovery and treatment interventions (ASAM Criteria, 2013).

- 4.5. 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).
- 4.6. 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).

5. Withdrawal Management/Detoxification Methods

- 5.1. Detoxification can usually be accomplished within 2 to 5 days or until the member's signs and symptoms can be managed at a less intensive level of care. Length of detoxification depends on a number of factors including withdrawal risk, substance(s) used, medical status, and severity of withdrawal symptoms (ASAM Criteria, 2013; CMS NCD Manual, Section 130.1).
- 5.2. Withdrawal management/detoxification medications are used to treat intoxication and withdrawal.
- 5.3. When managing intoxication, consider the following (APA Guideline, 2006):
 - 5.3.1. 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.
 - 5.3.2. 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.
 - 5.3.3. 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.
 - 5.3.4. Intubations to decrease aspiration or medications to support blood pressure are approaches that can be used to stabilize the physical effects of an overdose.
- 5.4. When managing withdrawal, consider the following (APA Guideline, 2006):
 - 5.4.1. Physically dependent individuals who discontinue their substance use after heavy or prolonged use may need to be monitored for withdrawal syndromes.

- 5.4.2. Consider factors that may influence severity of withdrawal (type of substance used and rate of metabolism or co-occurring conditions).
- 5.4.3. 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.
- 5.4.4. Treat with medications to ameliorate withdrawal symptoms such as clonidine for opioid withdrawal or benzodiazepines or anticonvulsants for alcohol withdrawal.
- 5.5. Specific attention should be given to the medication evaluation and management of members with active psychiatric and/or medical symptoms (ASAM Criteria, 2013).
- 5.6. Medications to treat co-occurring medical and/or psychiatric conditions may be chosen with close monitoring of possible interactions during the detoxification process.

6. Chemical Aversion Therapy

- 6.1. Disulfiram is an alcohol-aversive agent that causes acute toxic physical reactions when mixed with alcohol (SAMHSA TIP 49, 2009).
- 6.2. Chemical Aversion Therapy is most effective for members who have undergone detoxification or are in the initiation stage of alcohol abstinence and are receiving psychosocial treatments (SAMHSA TIP 49, 2009).
- 6.3. Because of the respiratory, cardiovascular and nervous system risks associated with disulfiram, it is essential for a physical exam and any relevant laboratory tests to be completed prior to beginning aversion therapy to determine if the member has a medical condition that may preclude Chemical Aversion Therapy (SAMHSA TIP 49, 2009).
- 6.4. Members with severely impaired judgment or who are highly impulsive as a result of severe mental illness or cognitive impairment may be inappropriate candidates (SAMHSA TIP 49, 2009).
- 6.5. Hepatic and cardiac side effects should be monitored throughout the course of disulfiram treatment (SAMHSA TIP 49, 2009).
- 6.6. Disulfiram should never be administered to a member who is intoxicated (SAMHSA TIP 49, 2009).
- 6.7. Chemical Aversion Therapy is typically administered in the following steps:

- 6.7.1. The member is educated about disulfiram and provides informed consent about the procedure (ASAM Principles of Addiction Medicine, 5th Edition, Uses of Aversion Therapy (ASAM Principles), 2014).
- 6.7.2. The member has abstained from alcohol for at least the last 12 hours (breath or blood alcohol level at zero) and is kept on clear liquids for 6 hours prior to the session (SAMHSA TIP 49, 2009; ASAM Principles, 2014).
- 6.7.3. The member has had a full physical exam to include liver and kidney function tests and electrocardiogram when indicated (SAMHSA TIP 49, 2009).
- 6.7.4. A complete medical and psychiatric evaluation has been completed to include allergies, medications, medical and psychiatric history (SAMHSA TIP 49, 2009).
- 6.7.5. The member will receive the prescribed supervised ingestion of disulfiram, with expected onset of emesis within 5 to 8 minutes (ASAM Principles, 2014).
- 6.7.6. The member is given an alcoholic beverage just prior to the onset of nausea to smell, swish around, and spit out (ASAM Principles, 2014).
- 6.7.7. The member will swish and swallow the alcohol, at which time vomiting will begin (ASAM Principles, 2014).
- 6.7.8. Each supervised treatment session typically lasts 3 hours. Five sessions is the typical duration of initial Chemical Aversion Therapy (ASAM Principles, 2014).
- 6.7.9. The disulfiram/alcohol interaction may last for up to 14 days after the last dosage was administered (SAMHSA TIP 49, 2009).
- 6.7.10. Maintenance therapy may continue on an outpatient basis with a typical dose of 250mg tabs of disulfiram taken unsupervised 1 time daily (SAMHSA TIP 49, 2009).
- 6.7.11. Depending on the member, daily dosing may be continued until the member has established stable, long-term abstinence, and could continue for months or years (SAMHSA TIP 49, 2009).

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. It is expected as a matter of good quality of care that careful discharge planning occur to enable a successful transition to outpatient care (CMS NCD Manual).
- 8.2. As the member moves through each level of care, his or her progress in all six dimensions should be formally assessed and re-assessed at regular intervals to determine the member's severity and intensity of services required (ASAM, 2013).
- 8.3. If the admission and continued stay criteria are no longer met, the following questions should be considered:
 - 8.3.1. Has the member achieved his/her goals identified in the treatment plan?
 - 8.3.2. Has the member been unable to resolve the problem justifying admission to the current level of care?

- 8.3.3. Has the member achieved the maximum possible benefit from engagement in services at the current level of care?
- 8.3.4. Has the member demonstrated a lack of capacity due to co-occurring conditions limiting his/her ability to resolve problems?
- 8.3.5. Is the member experiencing an intensification of symptoms?

PART VI: 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 VII: DEFINITIONS

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 use disorders, and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

PART VIII: REFERENCES

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15. Substance Abuse and Mental Health Services Administration (SAMHSA), Motivational Enhancement, Treatment Improvement Protocol 35, 2011. Retrieved from: <http://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Abuse-Treatment/SMA13-4212>
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17. Substance Abuse and Mental Health Service Administration (SAMHSA). Incorporating Alcohol Pharmacotherapies into Medical Practice, Treatment Improvement Protocol, 49. Retrieved from: <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

PART IX: 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
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

Limited to specific diagnosis codes?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

Limited to specific provider type?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

Limited to specific revenue codes?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

PART X: HISTORY

Revision Date	Name	Revision Notes
11/2014	L. Urban	Version 1-Final
6/2015	L. Urban	Version 2-Final
6/2016	L. Urban	Version 3-Final

The enrollee's specific benefit documents supersede these guidelines and are used to make coverage determinations. These Coverage Determination Guidelines are believed to be current as of the date noted.