



LEVEL OF CARE GUIDELINES: SUBSTANCE-RELATED DISORDERS

Guideline Number: BH803LOCGSRD_022018

Effective Date: February, 2018

Table of Contents	Page
INTRODUCTION	1
COMMON ADMISSION CRITERIA FOR ALL LEVELS OF CARE	2
COMMON CONTINUED SERVICE CRITERIA FOR ALL LEVELS OF CARE	2
COMMON DISCHARGE CRITERIA FOR ALL LEVELS OF CARE	3
COMMON CLINICAL BEST PRACTICES FOR ALL LEVELS OF CARE	3
GUIDELINES: OUTPATIENT	4
GUIDELINES: DETOXIFICATION, OUTPATIENT	5
GUIDELINES: OPIOID TREATMENT PROGRAM (OTP)	6
GUIDELINES: OFFICE-BASED OPIOID TREATMENT	7
GUIDELINES: INTENSIVE-OUTPATIENT PROGRAM (IOP)	10
GUIDELINES: PARTIAL HOSPITAL PROGRAM (PHP)	11
GUIDELINES: DETOXIFICATION, RESIDENTIAL	12
GUIDELINES: REHABILITATION, RESIDENTIAL	13
GUIDELINES: CRISIS STABILIZATION & ASSESSMENT	14
GUIDELINES: 23-HOUR OBSERVATION	15
GUIDELINES: DETOXIFICATION, INPATIENT	15
GUIDELINES: REHABILITATION, INPATIENT	16
REFERENCES	17
HISTORY/REVISION INFORMATION	18

INTRODUCTION

The *Level of Care Guidelines* is a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members’ recovery, resiliency, and wellbeing¹ for behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as OptumHealth Behavioral Solutions of California (“Optum-CA”).

The *Level of Care Guidelines* is derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The *Level of Care Guidelines* is also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators.

For more information on guiding principles for the *Level of Care Guidelines* and their development, approval, dissemination, and use, please see the *Introduction to the Level of Care Guidelines*, available at: www.providerexpress.com > Clinical Resources > Level of Care Guidelines.

¹ The terms “recovery” and “resiliency” are used throughout the Level of Care Guidelines. SAMHSA defines “recovery” as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. SAMHSA defines “resilience” as the ability to adapt well over time to life-changing situations and stressful conditions. The American Society of Addiction Medicine defines “recovery” as a process of overcoming both physical and psychological dependence on a psychoactive substance, with a commitment to sobriety, and also refers to the overall goal of helping a patient to achieve overall health and well-being.

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

COMMON ADMISSION CRITERIA FOR ALL LEVELS OF CARE

- The member is eligible for benefits.
AND
- The member's condition and proposed service(s) are covered by the benefit plan.
AND
- Service(s) are within the scope of the provider's professional training and licensure.
AND
- The member's current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care.
 - Failure of treatment in a less intensive level of care is **not** a prerequisite for authorizing coverage.AND
- 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 the factors leading to admission require the intensity of services provided in the proposed level of care.
AND
- Co-occurring behavioral health and medical conditions can be safely managed.
AND
- Service(s) are the following:
 - Consistent with generally accepted standards of clinical practice;
 - Consistent with services backed by credible research soundly demonstrating that the service(s) will have a measurable and beneficial health outcome, and are therefore not considered experimental;
 - Consistent with Optum's best practice guidelines;
 - Clinically appropriate for the member's behavioral health conditions based on generally accepted standards of clinical practice and benchmarks.AND
- There is a reasonable expectation that service(s) will improve the member's presenting problems within a reasonable period of time.
 - Improvement of the member's condition is indicated by the reduction or control of the signs and symptoms that necessitated treatment in a level of care.
 - 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.

COMMON CONTINUED SERVICE CRITERIA FOR ALL LEVELS OF CARE

- The admission criteria continue to be met and active treatment is being provided. For treatment to be considered "active", service(s) must be as follows:
 - Supervised and evaluated by the admitting provider;
 - Provided under an individualized treatment plan that is focused on addressing the factors leading to admission, and makes use of clinical best practices;
 - Reasonably expected to improve the member's presenting problems within a reasonable period of time.AND
- The factors leading to admission have been identified and are integrated into the treatment and discharge plans.
AND
- Clinical best practices are being provided with sufficient intensity to address the member's treatment needs.
AND
- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated.

COMMON DISCHARGE CRITERIA FOR ALL LEVELS OF CARE

- The continued stay criteria are no longer met. Examples include:
 - The 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.
 - The factors which led to admission cannot be addressed, and the member must be transitioned to a more intensive level of care.

- Treatment is primarily for the purpose of providing social, custodial, recreational, or respite care.
- The member requires medical/surgical treatment.
- The member is unwilling or unable to participate in treatment, and involuntary treatment or guardianship is not being pursued.

COMMON CLINICAL BEST PRACTICES FOR ALL LEVELS OF CARE

Evaluation & Treatment Planning

- The initial evaluation:
 - 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;
 - Focuses on the member's specific needs;
 - Identifies the member's goals and expectations;
 - Is completed in a timeframe commensurate with the member's needs, or otherwise in accordance with clinical best practices.
- The provider collects information from the member and other sources, and completes an initial evaluation of the following:
 - The member's chief complaint;
 - The history of the presenting illness;
 - The factors leading to the request for service;
 - The member's mental status;
 - The member's current level of functioning;
 - Urgent needs, including those related to the risk of harm to self, others, and/or property;
 - The member's use of alcohol, tobacco, or drugs;
 - Co-occurring behavioral health and physical conditions;
 - The member's history of behavioral health services;
 - The member's history of trauma;
 - The member's medical history and current physical health status;
 - The member's developmental history;
 - Pertinent current and historical life information;
 - The member's strengths;
 - Barriers to care;
 - The member's instructions for treatment, or appointment of a representative to make decisions about treatment;
 - The member's broader recovery, resiliency, and wellbeing goals.
- The provider uses the findings of the evaluation to assign a DSM-ICD diagnosis.
- The provider and, whenever possible, the member use the findings of the initial evaluation and diagnosis to develop a treatment plan. The treatment plan addresses the following:
 - The short- and long-term goals of treatment;
 - The type, amount, frequency, and duration of treatment;
 - The expected outcome for each problem to be addressed expressed in terms that are measurable, functional, time-framed, and directly related to the factors leading to admission;
 - How the member's family and other natural resources will participate in treatment when clinically indicated;
 - How treatment will be coordinated with other provider(s), as well as with agencies or programs with which the member is involved.
- 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. Examples include psychoeducation, motivational interviewing, recovery and resiliency planning, advance directive planning, and facilitating involvement with self-help and wraparound services.
- 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.
- Treatment focuses on addressing the factors precipitating admission 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.
- The treatment plan and level of care are reassessed when the member's condition improves, worsens, or does not respond to treatment.
 - When the member's condition has improved, the provider determines if the treatment plan should be altered, or if treatment is no longer required.
 - 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.

- 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.

Discharge Planning

- The provider and, whenever possible, the member develops an initial discharge plan at the time of admission, and estimates the length of treatment.
- The provider and, whenever possible, the member updates the initial discharge plan during the admission, ensuring that:
 - An appropriate discharge plan is in place prior to discharge;
 - The discharge plan is designed to mitigate the risk that the factors precipitating admission will reoccur;
 - The member agrees with the discharge plan.
- For members continuing treatment:
 - The discharge plan includes the following:
 - The discharge date;
 - The post-discharge level of care, and the recommended forms and frequency of treatment;
 - The name(s) of the provider(s) who will deliver treatment;
 - The date of the first appointment, including the date of the first medication management visit;
 - The name, dose, and frequency of each medication, with a prescription sufficient to last until the first medication management visit;
 - An appointment for necessary lab tests;
 - Resources to assist the member with overcoming barriers to care, such as lack of transportation or child care;
 - Recommended self-help and community support services;
 - Information about what the member should do in the event of a crisis prior to the first appointment.
- For members not continuing treatment:
 - The discharge plan includes the following:
 - The discharge date;
 - Recommended self-help and community support services;
 - Information about what the member should do in the event of a crisis or to resume services.
 - The provider explains the risk of discontinuing treatment when the member refuses treatment or repeatedly does not adhere with the treatment plan.

GUIDELINES: OUTPATIENT

Outpatient: *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 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 factors that precipitated admission no longer require treatment. Individual outpatient psychotherapy is generally provided in sessions lasting up to 45 minutes.*

Extended outpatient sessions are individual psychotherapy sessions with or without evaluation and management services lasting 60 minutes or longer (53+ minutes, per the CPT Time Rule). Extended outpatient sessions may require prior authorization before services are received, except in extenuating circumstances, such as a crisis. Please check the member's specific plan document.

Outpatient Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
- AND
- The member's current condition can be safely, efficiently, and effectively assessed and/or treated in this setting.

Coverage for extended outpatient sessions lasting longer than 60 minutes or longer (53+ minutes, per the CPT Time Rule) may be indicated in the following non-routine circumstances:

- The member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and an extended outpatient session is appropriate for providing rapid and time-limited assessment and stabilization.

- Consider extending coverage for acute crisis situations in 30-minute increments when clinically indicated.
- Prior authorization is not required when there is an acute crisis.
- An individual psychotherapy session with evaluation and management is being provided, and there is an unexpected complication resulting from pharmacotherapy, or an acute worsening of the member's condition that would likely require a more intensive level of care if the outpatient session is not extended.
- Periodic involvement of children, adolescent, or geriatric members' family in a psychotherapy sessions when such involvement is essential to the member's progress (e.g., when psychoeducation or parent management skills are provided).
 - This is not synonymous with marital or family therapy.
- An extended session is otherwise needed to address new symptoms of the reemergence of old symptoms with a rapid, time-limited assessment and stabilization response. Without an extended outpatient session, the new-re-emerging symptoms are likely to worsen and require a more intensive level of care.

Outpatient Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Outpatient Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Outpatient Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The frequency and duration of outpatient visits allows for safe, efficient, and effective achievement of treatment goals, and supports the member's recovery and resiliency. Initially, the frequency of visits varies from weekly in routine cases to several times a week. As the member's functional status improves, the frequency of visits decreases to meet the member's current needs and treatment goals. Factors that may impact frequency and duration include the following:
 - The goals of treatment;
 - The member's preferences;
 - Evidence from clinical best practices which supports frequency and duration;
 - The need to monitor and manage imminent risk of harm to self, others, and/or property.
- The provider informs the member of the process to be followed in the event of an after-hours emergency, such as the availability of on-call services. The process is not solely reliant on the Emergency Room.

GUIDELINES: DETOXIFICATION, OUTPATIENT

Detoxification, Outpatient: *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 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.

Detoxification, Outpatient Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member is not in imminent or current risk of harm to self or others, and/or property.
- AND
- The 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 the following:
 - A *Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised* (CIWA-AR) score < 10.
 - 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.

Detoxification, Outpatient Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Detoxification, Outpatient Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Detoxification, Outpatient Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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.
- 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.
- A psychiatrist or addictionologist is available to consult with the program during and after normal business hours.
- Access to laboratory and toxicology testing is available.
- Access to 24-hour emergency medical consultation is available.

GUIDELINES: OPIOID TREATMENT PROGRAM (OTP)

Opioid Treatment Program: *An Opioid Treatment Program (OTP) utilizes methadone or buprenorphine formulations in an organized, ambulatory, addiction treatment clinic for members with a severe Opioid-Use Disorder to pharmacologically occupy opiate receptors in the brain, extinguish drug craving and establish a maintenance state.*

OTPs are heavily regulated by federal agencies (e.g., SAMHSA 2016; SAMHSA 2014) and involve the direct administration of medications on a daily basis without prescription. OTP services are typically provided in permanent, freestanding clinics, community mental health centers, hospital medication units, and mobile units attached to a permanent clinic site.

The course of treatment in an Opioid Treatment Program is focused on addressing the 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.

Opioid Treatment Program Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member is diagnosed with an Opioid-Related Disorder
- AND
- The 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:
 - The member has no known contraindications to methadone or buprenorphine treatment.
 - The member does not have a co-occurring dependence on high doses of benzodiazepines or other central nervous system depressants, including alcohol.
- AND
- The member has been dependent on opioids for at least one year.
 - Treatment of a member who has been dependent on opioids for less than one year may be indicated when any of the following are present:
 - The member has been released from a correctional facility in the last 6 months.
 - The member received treatment in an OTP within the last 2 years.
 - A physician certifies that the member is pregnant.
 - The member is under age 18, has had at least 2 unsuccessful short-term detoxifications or drug-free treatment within the last 12 months, and the member's parent/guardian consents to OTP.
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- The member is willing to participate in a highly structured program with required daily attendance.
- AND
- The member is at high risk of relapse without opioid pharmacotherapy, close outpatient monitoring, therapy, and structured support within a programmatic milieu that promotes treatment progress and recovery.

Opioid Treatment Program Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Opioid Treatment Program Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Opioid Treatment Program Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- Induction Phase:
 - During the induction phase the member is transitioned from the opioid of abuse to daily methadone treatment.
 - Methadone is first administered during induction when there are no signs and symptoms of opioid use, or the use of sedatives, tranquilizers, tricyclic antidepressants, benzodiazepines, alcohol, or CNS depressants.
 - The standard induction dose is 20-30mg and each dose cannot exceed 30mg. The member should not receive more than 40mg in one day during induction unless the need is documented by the prescribing provider.
- Stabilization Phase:
 - During the stabilization phase, the provider monitors the member's response to treatment and level of motivation.
 - The standard dose is at least 80mg per day. Some members will achieve a therapeutic benefit with less than 80mg per day, while others require more than 120 mg per day.
 - As needed, the provider assists the member with developing a plan to gain employment, address legal problems, and manage co-occurring conditions.
 - Members younger than 18 should receive age-appropriate treatments, ideally with an adolescent-specific treatment track.
- Maintenance Phase:
 - The maintenance phase begins when the member is:
 - On a stable dose of methadone;
 - No longer experiencing withdrawal, side effects, or cravings for opioids;
 - Addressing psychosocial issues as part of the comprehensive treatment plan.
 - During the maintenance phase, the provider continues to monitor the member's response to treatment and level of motivation.
- When the end of treatment is indicated, the following occurs:
 - The provider gradually tapers the methadone dose in 5-10% increments every 1-2 weeks. The provider should remind the member that tapering may cause discomfort.
 - The member continues to participate in psychosocial interventions.
 - The provider, in conjunction with the member, schedules follow-up appointments with the OTP. Typically, follow-up appointments occur every 1-3 months.
- Involuntary discharge may be indicated when the member is violent or threatening, dealing drugs, repeatedly loitering, incarcerated, or is not compliant with treatment. Examples of interventions used to avoid involuntary discharge include:
 - Clarification of the program's rules;
 - Adjusting the dose of methadone;
 - Intensifying counseling;
 - Facilitating treatment of co-occurring conditions;
 - Enlisting the assistance of the member's family or other natural resources.

GUIDELINES: OFFICE-BASED OPIOID TREATMENT

Office-Based Opioid Treatment: *Office-Based Opioid Treatment includes medication-assisted treatments for members with Opioid-Related Disorders with the use of buprenorphine, naltrexone, or the combination of buprenorphine/naltrexone administered in a physician's office, Intensive Outpatient Program, or Partial Hospital Program. In this form of medication-assisted treatment, an opioid is substituted with the medically-managed use of the following medications:*

- Buprenorphine HCl sublingual tablets
- Buprenorphine HCl with naloxone HCl dehydrate sublingual tablets (Suboxone®)
- Oral naltrexone
- Extended-release injectable naltrexone (Vivitrol®)

Opioid Treatment services are delivered as a unique service, or as part of a larger comprehensive treatment plan. Community resources such as self-help, peer support groups, consumer-run services, and preventive health programs can augment medication-assisted treatments and support broader recovery/resiliency goals.

The course of Office-Based Opioid Treatment is focused on addressing the 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.

Office-Based Opioid Treatment Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)

AND

- The member is diagnosed with an Opioid-Related Disorder.

AND

- The 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 the following:
 - The member has no known contraindications to buprenorphine or naltrexone treatment.
 - The member is not dependent on high doses of benzodiazepines or other central nervous system depressants, including alcohol.

AND

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

Office-Based Opioid Treatment Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Office-Based Opioid Treatment Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Office-Based Opioid Treatment Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The provider is a physician who possesses at least one of the following:
 - A subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology;
 - An addiction certification from the American Board of Addiction Medicine (ABAM);
 - A subspecialty board certification in Addiction Medicine from the American Osteopathic Association (AOA).
- The provider has at least 8 hours of training on the treatment of opioid dependence provided by a Substance Abuse and Mental Health Services Administration (SAMHSA) approved organization, such as the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, or the American Psychiatric Association.
- The provider has secured a registration number and unique identification number from the Drug Enforcement Agency in order to administer buprenorphine.
- In accordance with the Drug Addiction Treatment Act of 2000, the provider maintains a caseload of up to 30 patients for the first year after petitioning the Drug Enforcement Agency for approval, and up to 100 patients thereafter.
- The provider has the capacity to provide or refer members for necessary ancillary services such as psychotherapy or recovery support services.

Buprenorphine Treatment Protocol

- Induction Phase:
 - During the induction phase, the member is transitioned from the opioid of abuse to buprenorphine.
 - Buprenorphine is first administered during induction after the member has abstained from using opioids for 12-24 hours, and is in the early stages of opioid withdrawal.
 - Induction is initiated in the physician's office using 4mg, followed by up to 4mg after 4 hours, if needed. Day 1 should not exceed 8mg. 4mg buprenorphine and 1mg naloxone in 2-4 hours, with additional 4mg buprenorphine and 1mg naloxone, if indicated, for buprenorphine-naloxone is recommended.
 - Induction continues in the physician's office with daily administration of increasing dosages of buprenorphine until a therapeutic dose is achieved.
 - During induction, the physician monitors the member's response to treatment and continued motivation to participate in comprehensive treatment that includes psychosocial interventions alongside buprenorphine treatment.
- Stabilization Phase:
 - During the stabilization phase, the provider monitors the member's response to treatment and level of motivation.
 - The frequency of office visits lessens, and the member may be transitioned to a prescription for use at home.
 - The standard dose is 12-16mg per day, although some members may need up to 32mg per day. The schedule of administration changes alternate days and the dose is increased to 24mg.
 - The dose may be increased if the member experiences withdrawal symptoms or feels compelled to use opioids.
 - Administration of up to 24mg on alternate days may be indicated when the member's condition has stabilized.
 - Use of buprenorphine at home is indicated when:

- The member abstains from using drugs and alcohol;
 - The member has regularly participated in Office-Based Opioid Treatment;
 - There are no significant behavioral problems;
 - There is no evidence of criminal activity;
 - There are no psychosocial or environmental problems;
 - The member can safely store the buprenorphine;
 - There is no risk that the buprenorphine will be diverted;
 - The member is participating in psychosocial interventions as per the treatment plan.
- Maintenance Phase:
 - The maintenance phase begins when the member is:
 - On a stable dose of buprenorphine;
 - No longer experiencing withdrawal, side effects, or cravings for opioids;
 - Addressing psychosocial issues as part of the comprehensive treatment plan.
 - During the maintenance phase, the provider continues to monitor the member's response to treatment and level of motivation.
 - The frequency of office visits during the maintenance phase is further reduced, and if indicated, the member continues to self-administer buprenorphine.
 - When the end of treatment is indicated, tapering occurs over a 2-3 week period. If significant withdrawal symptoms emerge, doses are split into 2-3 smaller doses until buprenorphine can be safely discontinued.

Oral Naltrexone Treatment Protocol

- Oral naltrexone is indicated when:
 - The member has completed detoxification 7-10 days prior to naltrexone therapy.
 - There is no evidence that the member has resumed using opioids.
 - The member is medically clear (e.g., normal liver functioning tests, negative toxicology screenings, negative pregnancy screening).
 - The member is motivated, or has a responsible person who is willing to monitor the member's compliance with treatment.
 - The member is not anticipating surgery nor has a medical condition for which opioids may be prescribed.
 - The member is willing to participate in psychosocial treatment.
- The initial oral naltrexone dose is 50mg/day in a single tablet. For members at risk (e.g., women, younger members, members with shorter abstinence), 12.5mg/day should be given for 1 week, with gradual weekly increases up to 50mg/day.
- The dose remains 50mg/day for up to 3 months, and oral maintenance may last up to 1 year.
- Discontinuation is not associated with withdrawal, so it is not necessary to taper the dose. The provider should remind the member that opioid medications should not be taken for at least 3 days following discontinuation, as the member may be more sensitive to the medication's effects.

Extended-Release Injectable Naltrexone (Vivitrol) Treatment Protocol

- Extended-release injectable naltrexone is indicated when:
 - The member and provider have determined naltrexone products (e.g., ReVia or Vivitrol) would be the optimal selection of agents used for opioid or alcohol use disorder, based on patient characteristics or preferences. In addition, naltrexone products may be considered for situations in which the member has not responded to other pharmacological and/or non-pharmacological forms of treatment, and not able to comply with oral naltrexone treatment.
 - The member has completed detoxification 7-10 days prior to naltrexone therapy.
 - There is no evidence that the member has resumed using opioids.
 - The member is medically clear (e.g., normal liver functioning tests, negative toxicology screenings, negative pregnancy screening).
 - The member does not have a bleeding disorder, is not obese, or otherwise has a condition that prevents deep intramuscular (IM) injections.
 - The member is not anticipating surgery or has a medical condition for which opioids may be prescribed.
 - The member is willing to participate in psychosocial treatment.
- Naltrexone is administered by intramuscular (IM) gluteal injection every 4 weeks at a dose of up to 380mg. If a dose is delayed or missed, the next injection is administered as soon as possible.
- There is no clearly defined duration of treatment with IM naltrexone, however a provider may consider discontinuation once the member's condition has stabilized, the member is able to maintain abstinence, has a support and recovery plan, and there is a reduced risk of relapse.
- The provider should remind the member that opioid medications should not be taken for at least 30 days following discontinuation as the member may be more sensitive to the medication's effects.

Psychosocial Interventions

- Pharmacotherapy alone is rarely a sufficient treatment for Opioid-Related Disorders. Psychosocial interventions vary according to a member's needs and may include:
 - Facilitation of access to behavioral health and medical services;
 - Individual or group participation in Motivational Enhancement Therapy, Cognitive Behavioral Therapy, or other therapies;
 - Coordination of behavioral health and medical services;
 - Psychoeducation;
 - Linking the member with peer services and other community resources, such as a sobriety support group or an accountability partner.

GUIDELINES: INTENSIVE-OUTPATIENT PROGRAM (IOP)

Intensive-Outpatient Program: 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. While an Intensive Outpatient Program generally maintains 9-19 hours of service for adults and 6-19 hours of service for children/adolescents per week, the frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

The purpose of services is to monitor and maintain stability, decrease moderate signs and symptoms, increase functioning, help members integrate into community life, and assist members with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.

The course of treatment in an Intensive Outpatient Program is focused on addressing the 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.

Intensive-Outpatient Program Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
- AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
- AND
- 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 the following:
 - Assessment requires frequent interaction with the member and observation of the member with others.
 - 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
- 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 the following:
 - The member requires a coordinated transition back into the community after treatment in inpatient or a residential treatment center.
 - The member has been unable to access or utilize family or other natural resources on his or her own.
- OR
- 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:
 - Maintain his or her current living situation;

- Return to work or school.

OR

- 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 the following:
 - Assistance with developing the skills needed to self-manage medications.
 - 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

- Overnight housing is covered by the benefit plan.
AND
- The treatment setting is separate from the housing.
AND
- Either of the following apply:
 - An unsupportive or high-risk living situation is undermining the member's recovery;
 - Routine attendance at the intensive outpatient program is hindered by a lack of transportation.

Intensive-Outpatient Program Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Intensive-Outpatient Program Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Intensive-Outpatient Program Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The responsible provider and the treatment team complete the initial evaluation commensurate with the member's needs, no later than three (3) treatment days following admission.
- During admission, a psychiatrist or addictionologist is available to consult with the program during and after normal program hours.
- The frequency of weekly visits provided to a member may less as the member nears discharge in order to promote a safe and timely transition between levels of care.

GUIDELINES: PARTIAL HOSPITAL PROGRAM (PHP)

Partial Hospital Program: *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. While a Partial Hospital Program generally maintains at least 20 hours of service per week, the frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.*

The purpose of services is to stabilize and reduce acute signs and symptoms, increase functioning, and assist a member with integrating into community life.

The course of treatment in a Partial Hospital Program is focused on addressing the 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.

Partial Hospital Program Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The member is not in imminent or current risk of harm to self, others, and/or property.
AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
AND

- Assessment and diagnosis and/or treatment planning requires observation and interaction for at least 20 hours per week. Examples include:
 - Assessment requires frequent interaction with the member, and observation of the member with others.
 - 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

- The member requires engagement and support, which requires extended interaction between the member and the program. Examples include:
 - 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.
 - The member has been unable to access or utilize the member's family or other natural resources on their own.

OR

- 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:
 - Maintain his or her current living situation;
 - Return to work or school.

OR

- 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:
 - Assistance with developing the skills needed to self-manage medications.
 - 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

- Overnight housing is covered by the benefit plan.
AND
- The treatment setting is separate from the housing.
AND
- Either of the following apply:
 - An unsupportive or high-risk living situation is undermining the member's recovery;
 - Routine attendance at the partial hospital program is hindered by a lack of transportation.

Partial Hospital Program Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Partial Hospital Program Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Partial Hospital Program Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The psychiatrist or addictionologist and the treatment team complete the initial evaluation commensurate with the member's needs, no later than 24 hours following admission.
- During admission, a psychiatrist or addictionologist is available to consult with the program during and after normal business hours.
- A psychiatrist or addictionologist sees the member commensurate with the member's needs, with no less than weekly visits.
- The frequency of weekly visits provided to a member may lessen as the member nears discharge in order to promote a safe and timely transition between levels of care.

GUIDELINES: DETOXIFICATION, RESIDENTIAL

Detoxification, Residential: *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 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 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.

Detoxification, Residential Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The 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 the following:
 - A *Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised* (CIWA-AR) score 10 to 18.
 - Withdrawal can be effectively, efficiently, and safely managed without the intensity of nursing care, medical monitoring, and physician availability provided in inpatient detoxification.

Detoxification, Residential Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating).
 - Health-related services 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.
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Detoxification, Residential Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Detoxification, Residential Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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.
- During admission, the psychiatrist or addictionologist sees the member commensurate with the member's needs, with no less than daily visits.
- The first treatment appointment and medication management visit are scheduled to occur with an urgency that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

GUIDELINES: REHABILITATION, RESIDENTIAL

Rehabilitation, Residential: *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 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.

Rehabilitation, Residential Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
AND
- The 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:
 - A co-occurring mental health condition is stabilizing, but the remaining signs and symptoms are likely to undermine treatment in a less intensive setting.
 - 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
- The 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:

- Acute impairment of behavior or cognition is interfering with Activities of Daily Living (ADLs) to the extent that the welfare of the member or others is endangered.
- Psychosocial and environmental problems threaten the member's safety, or undermine engagement in a less intensive level of care.

Rehabilitation, Residential Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating).
 - Health-related services 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.
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Rehabilitation, Residential Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Rehabilitation, Residential Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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.
- During admission, a psychiatrist is available to consult with the program during and after normal program hours. A psychiatric consultation occurs commensurate with the member's needs, with no less than weekly visits.
- The first treatment appointment and medication management visit are scheduled to occur with an urgency that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

GUIDELINES: CRISIS STABILIZATION & ASSESSMENT

Crisis Stabilization & Assessment: *A program in which the factors that precipitated the need for service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member's condition can be safely, efficiently, and effectively treated in a less intensive level of care, or it is determined that the member's condition requires treatment in a more intensive level of care.*

There are different types of Crisis Stabilization & Assessment programs. For example, mobile crisis teams are designed to rapidly triage members in crisis who are unable or unwilling to go to an Emergency Room or a facility-based Crisis Stabilization & Assessment program.

More extended and extensive services are offered in Crisis Stabilization & Assessment programs which employ behavioral health professionals and peers to deliver a range of 24-hour services over the course of several days. These programs may be freestanding or co-located with another facility-based program, and the services they provide may include crisis stabilization with/without medication management, peer support, recovery/resiliency planning, an organized sobriety group, social and recreational activities, facilitated access to the next appropriate level of care, and information about community resources.

Crisis Stabilization & Assessment Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
- OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

Crisis Stabilization & Assessment Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

Crisis Stabilization & Assessment Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Crisis Stabilization & Assessment Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The focus of the evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.
- The evaluation addresses:
 - Presenting concerns;
 - Urgent needs, including those related to the risk of harm to self, others, or property;
 - The history of crises, including:
 - Response to prior initiatives;
 - Issues since last crisis stabilization;
 - Current living situation;
 - Availability of supports;
 - Current treatment;
 - Use of alcohol or drugs;
 - Co-occurring behavioral health or medical conditions.
- The treatment plan addresses:
 - The member's urgent needs;
 - Immediate services needed to respond to the current crisis;
 - How the member's family and other natural resources will be involved in resolving the crisis when clinically indicated;
 - How the member will be transitioned to other services.

GUIDELINES: 23-HOUR OBSERVATION

23 Hour Observation: *A program that provides a medically-safe environment for up to 23 hours during which the factors that precipitated the need for service (e.g., changes in the member's signs and symptoms, psychosocial and environmental factors, or level of functioning) are rapidly assessed and stabilized to the point that the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or it is determined that the member's condition requires treatment in a more intensive level of care.*

23 Hour Observation Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
- AND
- The factors leading to admission and/or the member's history of treatment suggest that the member is likely to respond to rapid assessment and stabilization.
- OR
- The factors leading to admission require immediate assessment and intervention to determine if admission to an inpatient setting is warranted.

23 Hour Observation Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)

23 Hour Observation Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

23 Hour Observation Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- The focus of the evaluation and treatment planning is to determine whether the member's condition can be safely, efficiently, and effectively treated in an ambulatory setting, or whether the member should be admitted to an inpatient setting.

GUIDELINES: DETOXIFICATION, INPATIENT

Detoxification, Inpatient: *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 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 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.

Detoxification, Inpatient Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- The factors leading to admission suggest that there is imminent or current risk of severe withdrawal with or without serious medical complications. Examples include the following:
 - A *Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised* (CIWA-AR) score \geq 19.
 - The member has a history of withdrawal seizures.

Detoxification, Inpatient Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating).
 - Health-related services 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.
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Detoxification, Inpatient Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Detoxification, Inpatient Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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.
- During admission, the psychiatrist or addictionologist sees the member commensurate with the member's needs, with no less than daily visits.
- The first treatment appointment and medication management visit are scheduled to occur with an urgency that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

GUIDELINES: REHABILITATION, INPATIENT

Rehabilitation, Inpatient: *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 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 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.

Rehabilitation, Inpatient Admission Criteria

- See [Common Admission Criteria for All Levels of Care](#)
AND
- There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
AND
- The 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:
 - A co-occurring mental health condition has worsened and the member's behavior has become more impulsive.
 - 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

- The 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:
 - Alcohol or drug use has caused a medical complication that can be safely managed in this setting.
 - A severe medication side effect requires the level of monitoring and intervention available in inpatient rehabilitation.
- OR
- The factors leading to admission cannot be safely, efficiently, and effectively 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:
 - Acute impairment of behavior or cognition is interfering with Activities of Daily Living (ADLs) to the extent that the welfare of the member or others is endangered.
 - Psychosocial and environmental problems threaten the member’s safety, or undermine engagement in a less intensive level of care.
- OR
- The 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.

Rehabilitation, Inpatient Continued Service Criteria

- See [Common Continued Service Criteria for All Levels of Care](#)
- Treatment is not primarily for the purpose of providing custodial care. Services are custodial when they are any of the following:
 - Non-health-related services, such as assistance with Activities of Daily Living (examples include feeding, dressing, bathing, transferring, and ambulating).
 - Health-related services 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.
 - Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Rehabilitation, Inpatient Discharge Planning and Criteria

- See [Common Discharge Criteria for All Levels of Care](#)

Rehabilitation, Inpatient Clinical Best Practices

- See [Common Clinical Best Practices for All Levels of Care](#)
- 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.
- During admission, the psychiatrist or addictionologist sees the member at least 5 times per week, evaluates the treatment program to determine the extent to which treatment goals are being realized, and changes the treatment plan as needed.
- The first treatment appointment and medication management visit are scheduled to occur with an urgency that is commensurate with the risk that the factors which led to admission will reoccur, but no later than 7 days from discharge.

REFERENCES

- American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with substance use disorders. *J Am Acad Child Adolesc Psychiatry* 2005; 44(6):609-621.
- American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. *J Am Acad Child Adolesc Psychiatry* 2001; 40(7 Suppl):24S-51S.
- American Association of Community Psychiatrists. *Child and adolescent level of care utilization system (CALOCUS)* 2010.
- American Association of Community Psychiatrists. *Level of care utilization system (LOCUS) for psychiatric and addiction services: Adult version 2010*.
- American Psychiatric Association. *Diagnostic and statistical manual of mental disorders* (5th ed.) 2013; Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association. *Practice guidelines for the psychiatric evaluation of adults* (3rd ed.) 2016; Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders (2nd ed.) 2006; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. Guideline watch (April 2007): Practice guideline for the treatment of patients with substance use disorders, 2nd edition. 2007; Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. *Practice guideline for the assessment and treatment of patients with suicidal behaviors* 2003; Arlington, VA: American Psychiatric Publishing.

Association for Ambulatory Behavioral Healthcare. *Standards and guidelines for partial hospital programs* (5th ed.) 2015. Association for Ambulatory Behavioral Healthcare.

Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol (TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, No. 35 HHS Publication No. (SMA) 13-4212. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013 (Original Publication Printed 1999).

Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014 (Original Publication Printed 2005).

Center for Substance Abuse Treatment. *Screening and Assessing Adolescents for Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series, No. 31. HHS Publication No. (SMA) 12-4079. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012 (Original Publication Printed 1998).

Centers for Medicare and Medicaid Services. *Benefit policy manual, chapter 6 – hospital services covered under part B* 2015. Retrieved from: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c06.pdf>

Centers for Medicare and Medicaid Services. *Local Coverage Determination (LCD): Outpatient observation bed/room services* (L34552). Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34552&ver=14&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=outpatient+observation&KeywordLookup=Title&KeywordSearchType=And&bc=gAAAAACAAAAAAAAA%3d%3d&>

Centers for Medicare and Medicaid Services. *Local Coverage Determination (LCD): Psychiatric Partial Hospitalization Programs* (L33972; L34196; L33626). Retrieved from: <https://www.cms.gov/medicare-coverage-database/search/search-results.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&Keyword=psychiatric+partial&KeywordLookup=Title&KeywordSearchType=And&bc=gAAAAAAAAAAAAAAAA%3d%3d=&>

Centers for Medicare and Medicaid Services. *National Coverage Determination (NCD) for Inpatient Hospital Stays for Treatment of Alcoholism (130.1)*. Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=26&ncdver=1&bc=AAAAGAAAAAAAAA%3d%3d&>

Centers for Medicare and Medicaid Services. *National Coverage Determination (NCD) for Withdrawal Treatments for Narcotic Addictions (130.7)*. Retrieved from: <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=59&ncdver=1&bc=AAAAGAAAAAAAAA%3d%3d&>

Commission on Accreditation of Rehabilitation Facilities. *Behavioral health standards manual* 2015. Tucson, AZ: CARF International.

Management of Substance Use Disorders Work Group. VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorders, version 3.0. Washington, DC: Veterans Health Administration and Department of Defense; 2015.

Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., & Miller, M.M., (eds). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*. 3rd ed. Carson City, NV: The Change Companies; 2013.

Murphy S, Irving CB, Adams CE, & Driver R. Crisis intervention for people with severe mental illnesses. *Cochrane Database Syst Rev* 2012; (5):CD001087.

Substance Abuse and Mental Health Services Administration. *An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People with Opioid Dependence*. Advisory 2012; Volume 11, Issue 1.

Substance Abuse and Mental Health Services Administration; U.S. Department of Health and Human Services. *Medication Assisted Treatment for Opioid Use Disorders*; 42 CFR Part 8 FR 44738, July, 2016. Retrieved from: <http://www.ecfr.gov/cgi-bin/text-idx?SID=dcdb5c85cd507f55c7864a28bdb2a2dc&mc=true&node=pt42.1.8&rgn=div5>

HISTORY/REVISION INFORMATION

Date	Action/Description
01/10/2017	• Version 1 (Approved by UMC)

Date	Action/Description
02/07/2018	• Version 2 (Approved by UMC)