Clinical Policy: Substance Use Disorders

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Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

DESCRIPTION

This policy applies to all staff involved in the design, implementation, operations, and management of Behavioral Health utilization management services for Louisiana Healthcare Connections / Centene Advanced Behavioral Health (CABH) for the Medicaid line of business. This clinical policy outlines the utilization management of authorization requests for substance use disorder treatment within Louisiana Healthcare Connections.

POLICY/CRITERIA

For substance use disorder (SUD) medical necessity coverage determinations and authorization requests for plans managed by CABH it is the utilize The American Society of Addiction Medicine (ASAM) Criteria, Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition. The ASAM Criteria include both adult and adolescent criteria and incorporate both substance use disorders and co-occurring disorders within the criteria. In addition to ASAM, other evidence-based guidelines such as, but not limited to, InterQual SUD Criteria located within the Centene Management System may also be applied to determine the medical necessity of SUD treatment.

BACKGROUND

Substance use disorders (SUD) are chronic, relapsing medical conditions that have genetic, environmental and exposure origins that involve neurobiological brain circuit changes which result in compulsive use of substances. These substances include illicit drugs or agents as well as legal agents and prescriptions and belong to a variety of classes. SUDs are often co-morbid with other psychiatric and general medical conditions and can be fatal. They are devastating to individuals, communities and society at large. The United States leads the world in opioid prescriptions, which is a risk factor for substance use disorder. Up to 30% of those prescribed opioids abuse their prescriptions and 12% of those develop a substance use disorder.[26] Only 10% of individuals with SUD in the USA get treatment. Oftentimes, when individuals seek treatment, they encounter a system that is fraught with bias/stigma, fragmented and uncoordinated. However, when they do get appropriate treatment, individuals recover from SUD at similar rates as from other chronic medical conditions. CABH policy on substance use treatment is based on the best current evidence for treatment that supports recovery. The ASAM Criteria guiding principles of this care are the following:

1. Comprehensive: Incorporates all current evidence-based treatments, including medication assisted treatment. Treatment should address medical, mental health and social determinants.
2. Patient-Centered: Individualized, flexible treatment approach.

3. Does not require a "fail first": current standards recommend all indicated treatments be implemented at the time the individual seeks treatment, without requiring other types/levels of care be "failed first."
4. Parity: SUD treatment should be covered equally with other medical treatments as required under parity laws.
5. Least restrictive: Consistent with other medical treatment, less restrictive medically necessary treatment options should be considered when these less restrictive options are considered both equally safe and equally effective compared to higher levels of care.
6. Motivation and Member Engagement: Client motivation and engagement are at the heart of any successful treatment. Motivational enhancement techniques should be incorporated at every stage of client contact.

THE ROLE OF MEDICATION-ASSISTED TREATMENT (MAT) IN SUBSTANCE USE TREATMENT

There is a strong evidence base for the efficacy of medication in the treatment of substance use disorders when combined with psychotherapy and behavioral strategies. This is called medication-assisted treatment (MAT). MAT is considered the standard of care for opioid and other substance use disorders. This type of treatment falls into two broad categories:

- Medications used to support abstinence and recovery maintenance.
- Medications used to manage withdrawal or intoxication.

Categories of medication used to support abstinence and recovery:

- Antagonist medications e.g., naltrexone/Vivitrol®
- Agonist medications e.g., methadone, nicotine replacement therapies.
- Partial agonist medications e.g., Buprenorphine, Varenicline®
- Novel mechanisms of action e.g., acamprosate/Campral R
- Aversive agents such as Disulfiram (Antabuse®)
- Novel treatments/alternative mechanisms of action/off-label use: e.g. (Gabapentin & Baclofen for alcohol use disorders), Bupropion (for smoking cessation).

Medications used primarily to treat overdose and withdrawal states:
Medication can be used to treat withdrawal symptoms and facilitate a safer medical withdrawal when warranted. Others can be used to treat overdose states. When using drugs to mediate withdrawal, use of rating scales are strongly recommended. Examples are the CIWA-Ar and COWS. These scales enable the provider to evaluate the severity of withdrawal and to determine the best treatment course.

Drugs used to treat intoxication or overdose states include

- Naloxone*:* used to reverse opioid overdose. Several different formulations exist, from intranasal to intramuscular; this may be lifesaving in overdose.
- Flumazenil: used to reverse benzodiazepine overdose.

Opioid Withdrawal Protocols:

Using Opioid Substitution:

- Buprenorphine
- Methadone

- Using clonidine and other comfort medications. Lofexidine has a similar mechanism of action as clonidine and is FDA approved for treating opioid withdrawal. However, its higher cost may be a consideration in its use.

Alcohol Withdrawal Protocols:
- Using benzodiazepine substitution
- Using phenobarbital substitution
- Using anticonvulsants meds (gabapentin, carbamazepine)
- Always administer B1 (thiamine) 250-500 mg TID depending on presentation; parenteral route is preferred and can be transitioned to once daily dosing oral treatment as individual recovers

Sedative-Hypnotics Withdrawal Protocols:
- Using phenobarbital substitution
- Using clonazepam substitution
- Using another benzodiazepine substitution
- B vitamins, especially B12, folate, thiamine and PRN comfort meds addressing peripheral symptoms of withdrawal should be used as needed. Adequate Magnesium levels should be assured.

Medications used to maintain abstinence and to support recovery:
There now exists a strong evidence base for the use of medication to maintain abstinence and support recovery during SUD Treatment. Such medications, when combined with counseling and behavioral therapies, increase retention rates, and are associated with better health and social outcomes for some patients. They should be offered to all individuals seeking treatment for those substance use disorders where there is clinical evidence of their efficacy unless there is a medical contraindication. Best practices recommended by National Institute of Drug Abuse (NIDA) and American Society of Addiction Medicine (ASAM) regarding Medication Assisted Treatment implementation include:
- Medication to decrease urges or cravings for alcohol
  - ✓ Acamprosate: Administer after a minimum of five days abstinence from alcohol. Start at 333 mg TID for 3 days and then increase to 666 mg TID; this should be offered as an integral part of the SUD treatment recommendation to all patients with alcohol use disorder and reporting cravings >3/10 as soon as they have been managed for withdrawal and throughout their SUD treatment stages as long as they are experiencing benefit from the medication as noted by lowered levels of craving, reduced rumination and abstinence maintenance.
- Medications to decrease the reinforcing effects of alcohol
  - ✓ Naltrexone PO: usual daily dose is 50 mg; this should be offered as an integral part of the treating alcohol use disorder. Alternative dosing is possible. Liver enzymes should be monitored during treatment.
  - ✓ Naltrexone depot IM (Vivitrol): 380 mg IM every 4 weeks; this should be offered as part of the integral treatment plan recommendations to the same patients as noted above after they have shown good tolerance to Naltrexone PO and prefer this route or have continued to be high risk for relapse.
- Medications to decrease urges or cravings for opioids
  - ✓ Naltrexone: patients must be opioid free 7-14 days; this should be reviewed and offered as an integral part of the SUD treatment recommendation to all opioid use

disorder patients as ONE of the three FDA approved medications to reduce reported ongoing cravings. While oral naltrexone is available to patients with OUD, injectable naltrexone is recommended given the risk of reduced tolerance in patients who have stopped using opioids for a period of time, therefore increasing the risk of overdose should that person not continue to take the oral medication.

- ✓ Naltrexone depot IM (Vivitrol®): 380 mg IM every 4 weeks; this formulation is recommended over the oral form for opioid use disorder. This should be offered as an integral part of the treatment planning to patients who choose to take an antagonist to reduce cravings and reduce the risk of relapse. The patients can be started on this after they have shown tolerance to a naloxone challenge or Naltrexone PO (even after one dose).

- Agonist or mixed agonist/antagonist maintenance therapies:
  - ✓ Opioids: This should be offered as part of the treatment planning options to opioid use disorder patients.
  - ✓ Methadone: 40-60 mg/day or less of methadone is usually sufficient to block opioid withdrawal symptoms. Higher doses (80-120 mg/ day) have been shown to curb dramatically additional use of opioids.
  - ✓ Buprenorphine-only formulations: in some practices used for pregnant patients or in those with an adverse reaction to naloxone.
  - ✓ Buprenorphine/naloxone combination (ranging between mg/0.5 mg – 32 mg/8 mg per day, sublingual once daily or in divided doses). Typical daily doses rarely exceed 16/4 mg in ambulatory settings. The dosing is based on individual histories and needs.

Abstinence-promoting and relapse prevention therapies for alcohol:

- ✓ Disulfiram: Usual Dose 250 Mg/Day, Rarely: 125 Mg/Day – 500 Mg/Day (Typically Aversive If Used With Alcohol). This medication can be helpful for patients who continue to be unable to avoid consuming alcohol despite use of other medications as listed and have an individual willing to 'witness dose' the patient. Studies do not bear out that disulfiram has long term benefit for patients with alcohol use disorder unless under this condition. Liver function tests and complete blood counts should be checked periodically.
- ✓ Psychosocial evaluation within 48 hours
- ✓ Individual or group therapy at least 2x/day
- ✓ Recovery or education group daily
- ✓ Family therapy at least 1x/week
- ✓ Nursing staff observation 24 hours/day
- ✓ Educational assessment for patients aged 13-17
- ✓ Self-help group recommended

Additional MAT Considerations

Duration of MAT Use: In accordance with the principles of person-centered care, it is no longer recommended to place arbitrary limits on duration of MAT. Similar with treatment of other chronic medical conditions such as diabetes, asthma, hypertension and cancer, many individuals will require long term or lifetime treatment with MAT. Treatment planning is determined between the provider and the patient and in conjunction with other multidisciplinary team members.

Long-Acting Drug Formulations: There now exist several long – acting formulations of drugs used for MAT.

- Long-acting injectable naltrexone (Vivitrol®)
- Long-acting injectable buprenorphine (Sublocade®).
- Long-acting implantable buprenorphine (Propbuphine®)

These formulations may be especially helpful in individuals who struggle with adherence. They may also be useful in individuals who have stabilized and require maintenance treatment.

MAT in Special Populations:

- Pregnancy
- Adolescents
- Reentry populations
- Chronic infections: HIV/Hepatitis C positive, tuberculosis.

Special considerations apply in the treatment of those who are pregnant, adolescent individuals, those with chronic infections and of those who are re-entrants from corrections. These populations are particularly vulnerable and may especially benefit from MAT. For others, dose or medication adjustments may be needed. For example, in adolescents and pregnant women. Women who become pregnant while on naltrexone or Vivitrol® may need to be switched to an agonist such as methadone or partial agonist such as buprenorphine, though retrospective studies are now beginning to support continued antagonist treatment in pregnancy. As of this date, it is not standard of care. When treating adolescents, age considerations will need to be reviewed based on medication age approvals while maintaining a focus on unique individual treatment needs.

"Medication First" and Other Emerging National Models: In response to the Opioid epidemic, states are experimenting with different models of leveraging MAT in addiction treatment. A prominent example is the "Medication first" model in Missouri State.[1] Medication first is conceptually similar to the Housing First model. Its core principles are as follows:

- People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
- Pharmacotherapy is discontinued only if it is worsening the person's condition.

While this model is in its early stages of implementation, there is a solid basis for it. Efforts to accommodate similarly innovative models should be made on a local and state level.

LEVEL OF CARE GUIDELINES

The ASAM Criteria Level of Care Guidelines are used upon admission to assess the need for continued care, and discharge from each level of care. In addition to ASAM, other evidence-based guidelines such as, but not limited to, InterQual SUD Criteria located within the Centene Management System may also be applied to determine the medical necessity of SUD treatment. Since SUDs are chronic, relapsing disorders with a highly

[1] https://missouriopioidstr.org/updates/2018/9/13/medication-first-model-1-pager

variable course, they often require intensive, sustained, coordinated and comprehensive treatment. This is similar to diabetes or cancer treatment. Current standards advocate the incorporation of MAT, counseling, psychosocial treatments, relapse prevention strategies, and concurrent treatment of co-occurring mental health and medical conditions.

ASAM CRITERIA LEVEL OF CARE GUIDELINES

When paired with MAT, counseling, psychosocial treatments and attention to social determinants, ambulatory treatment at ASAM levels 1 through 2.1 can be as, or more effective than more intensive treatment at higher ASAM levels. Louisiana Healthcare Connections uses ASAM criteria Level of Care Guidelines and other evidence-based guidelines to outline objective and evidence-based criteria to standardize coverage determinations and utilization management (UM) practices for Louisiana Healthcare Connections BH UM function. The Substance use Disorders (SUD) Criteria are designed for patients **13 years of age and older presenting with a predominant symptom of a SUD.**

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

ASAM Level IV: Medically Managed Intensive Inpatient Services

This level of care occurs in an acute care or psychiatric inpatient hospital unit for patients with acute biomedical, emotional, behavioral, and cognitive problems so severe that they require primary medical and nursing care. Patients may require acute medical treatment to address acute intoxication and/or withdrawal potential 24 hours/day for medical issues related to substance use; complex SUD with severe psychiatric symptoms; or in acute danger of medical complications related to substance use and require a 24-hour medical management to ensure safety.

Evaluation and Treatment

Service delivery will vary based on legislative and organizational policy as well as geographic variances but, at a minimum, should include:

- Care coordination with other care providers and social services
- Toxicology screen within 4 hours
- Nursing assessment within 8 hours of admission
- Substance use evaluation within 8 hours
- Discharge plan initiated within 24 hours
- Medical history or physical exam initiated within 24 hours
- Psychiatric evaluation, initial within 24 hours prior to or within 24 hours after admission – subsequently at least once a day
- Daily physician evaluations
- Medication management daily
- Medication reconciliation within 24 hours
- Psychosocial evaluation within 48 hours
- Multidisciplinary treatment plan within 48 hours
- Individual or group or family therapy daily
- Nursing staff observation 24 hours/day
- Educational assessment for patients aged 13-17

- Toxicology screen as clinically indicated, education group, or self-help as needed

ASAM Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management

Level 4-WM provides medical support and comfort care needed for:

- Patients that require monitoring or intervention more frequently than hourly; or
- Need stabilization while pregnant, until the patient can be safely treated in a less intensive level of care.

Inpatient withdrawal criteria are used for a patient who has been or is expected to be admitted to an inpatient unit and requires medically managed withdrawal services. Patients may require acute medical treatment to address acute intoxication and/or withdrawal potential 24 hours/day for medical issues related to substance use; complex SUD with severe psychiatric symptoms; or in acute danger of medical complications related to substance use and require a 24-hour medical management to ensure safety. Maintenance medications may be considered at this level of care. Medications used primarily to treat ***intoxication and withdrawal states*** will require consistent use of withdrawal measuring scales (CIWA-R, COWS) to evaluate severity of withdrawal signs and symptoms and determine appropriate taper of substitution medications:

- Opioid Withdrawal Protocols using opioid substitutions
  - ✓ Buprenorphine
  - ✓ Methadone
  - ✓ Other opioids
- Using clonidine
- Alcohol Withdrawal Protocols:
  - ✓ Using benzodiazepine substitution
  - ✓ Using phenobarbital substitution
  - ✓ Using anticonvulsants meds (gabapentin, carbamazepine)
- Sedative-Hypnotics Withdrawal Protocols:
  - ✓ Using phenobarbital substitution
  - ✓ Using clonazepam substitution
  - ✓ Using other benzodiazepine substitution.
  - ✓ Always administer B1 (thiamine) 250-500 mg TID depending on presentation; parenteral route is preferred and can be transitioned to once daily dosing oral treatment as individual recovers.

Evaluation and Treatment

- B vitamins, especially B12, folate, thiamine and PRN comfort meds addressing peripheral symptoms of withdrawal should be used as needed
- Service delivery will vary based on legislative and organizational policy as well as geographic variances but, at a minimum, should include:
  - ✓ Care coordination with other care providers and social services
  - ✓ Toxicology screen within 4 hours
  - ✓ Nursing assessment within 8 hours of admission
  - ✓ Substance use evaluation within 8 hours
  - ✓ Discharge plan initiated within 24 hours
  - ✓ Medical history or physical exam initiated within 24 hours
  - ✓ Psychiatric evaluation, initial within 24 hours prior to or within 24 hours after admission – subsequently at least 1x/day

- ✓ Medication reconciliation within 24 hours
- ✓ Psychosocial evaluation within 48 hours
- ✓ Multidisciplinary treatment plan within 48 hours
- ✓ Daily physician evaluation
- ✓ Individual or group or family therapy daily
- ✓ Nursing staff observation 24 hours/day
- ✓ Educational assessment for patients aged 13-17
- ✓ Toxicology screen as clinically indicated, education group, or mutual help as needed

ASAM Level 3.7: Medically Monitored Inpatient Programs / Co-Occurring Enhanced Program (intensive for adults; high intensity for adolescents)
These services are differentiated from Level 4.0 in that the population served does not have conditions severe enough to warrant medically managed inpatient services or acute care in a general hospital where daily treatment decisions are managed by a physician. Level 3.7 is appropriate for adults and adolescents with co-occurring psychiatric disorders or symptoms that hinder their ability to successfully engage in SUD treatment in other settings. Services in this program are meant to orient or re-orient patients to daily life structures outside of substance use and requires 24-hour nursing/medical monitoring under the direction of a physician as part of a psychotherapeutic program. The main focus is to safely treat patients at high risk for withdrawal from substances and support patients to acknowledge, recognize and understand their SUD in order to safely transfer to a less intensive level of care.

NOTE: Patients in *Level 3.7 co-occurring enhanced program* meets the diagnostic criteria for a mental disorder as well as a substance use or addictive disorder, as defined in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association or other standardized and widely accepted criteria, as well as the dimensional criteria for admission, specifically Dimension 3, 4, 5, and 6.

In *Level 3.7 Co-Occurring Enhanced Program,* patients have moderate acute emotional, behavioral, and cognitive problems that they require primary medical and nursing care as part of a psychotherapeutic program. Patients may require acute medical treatment to address psychiatric symptoms and/or withdrawal potential 24 hours/day for medical issues related to substance use; complex SUD with moderate psychiatric symptoms; or in acute danger of medical complications related to substance use and require a 24-hour medical management to ensure safety.

Evaluation and Treatment
Service delivery will vary based on legislative and organizational policy as well as geographic variances but, at a minimum, should include:

- Care coordination with other care providers and social services
- Discharge plan initiated upon admission
- Multidisciplinary treatment plan upon admission
- Toxicology screen as clinically indicated or breathalyzer within 4 hours and subsequently as needed
- Nursing assessment by a registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission within 8 hours of admission

- Substance use evaluation within 24 hours
- Medical history or physical exam initiated within 24 hours
- Physician evaluation within 24 hours of admission and daily thereafter while in the hospital setting (a physician assistance, nurse practitioner or psychologist can perform when legally authorized by the state)
- Medication reconciliation initiated within 24 hours

ASAM Level 3.5: Clinically Managed Residential Programs (high intensity for adults, medium intensity for adolescents)
The Residential Treatment Criteria are used for a patient who has been or is expected to be admitted to a SUD Residential Treatment Center (RTC). This level of care is also referred to as clinically managed high or medium (for Adolescents) intensity residential services and considered a Level 3.5 ASAM. Services are provided 24 hours/day, 7 days/week in a facility licensed for residential SUD treatment.
Evaluation and Treatment
Service delivery will vary based on legislative and organizational policy as well as geographic variances but, as best practices should include at a minimum, should include:
- Structured therapeutic program at least 6 hours/day
- Preliminary discharge plan initiated within the 7th day of admission.
- Medication reconciliation initiated within 24 hours
- Psychosocial and substance use evaluation within 48 hours
- Medication supervision or administration daily

ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Programs (specified for adults only)
This degree of residential treatment is specifically designed for specific adult populations with significant cognitive impairments resulting from substance use or other co-occurring disorders.
- High-Intensity Residential Programs are appropriate when an adult's temporary or permanent cognitive limitations make it unlikely for them to benefit from other residential levels of care that offer group therapy and other cognitive-based relapse prevention strategies.
- Cognitive impairments may be seen in individuals who suffer from an organic brain syndrome as a result of substance use, who suffer from chronic brain syndrome, who have experienced a traumatic brain injury, who have developmental disabilities, or are older adults with age and substance-related cognitive limitations.
- Individuals with temporary limitations receive slower paced, repetitive treatment until the impairment subsides and the patient is able to progress onto another level of care appropriate for their SUD treatment needs.
- Settings include structured, therapeutic rehabilitation facilities and traumatic brain injury programs located within a community setting, or in specialty units located within licensed healthcare facilities where high-intensity clinical services are provided in a manner that meets the functional limitations of patients. Such programs have

direct affiliation with more or less intensive levels of care as well as supportive services related to employment, literacy training and adult education.
- Physicians, physician extenders, and appropriate credentialed mental health professionals may lead treatment.
- On-site 24-hour allied health professional staff supervise the residential component with access to clinicians competent in SUD treatment.
- Clinical staff knowledgeable about biological and psychosocial dimensions of SUD and psychiatric conditions who have specialized training in behavior management support care.
- Patients have access to additional medical, laboratory, toxicology, psychiatric and psychological services through consultations and referrals.
- Specialized services are provided at a slower pace and in a repetitive manner to overcome comprehension and coping challenges.
- This level of care is appropriate until the cognitive impairment subsides, enabling the patient to engage in motivational relapse prevention strategies delivered in other levels of care.
- Level 3.3 clinically managed population-specific high-intensity residential services may be provided in a deliberately repetitive fashion to address the special needs of individuals for whom a Level 3.3 program is considered medically necessary.
- Daily clinical services designed to improve the patient's ability to structure and organize the tasks of daily living and recovery, to stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills are provided.
- The skilled treatment services include a range of cognitive, behavioral and other therapies administered on an individual and group basis; medication management and medication education; counseling and clinical monitoring; educational groups; occupational and recreational therapies; art, music or movement therapies; physical therapy; clinical and didactic motivational interventions; and related services directed exclusively toward the benefit of the Medicaid-eligible individual.

ASAM Level 3.1: Clinically Managed Low-Intensity Residential Programs
The criteria are used for patients that have been or are expected to be admitted to a supervised living residence. Services are provided in a 24-hour environment, such as a group home. Both clinic-based services and community-based recovery services are provided. Clinically, Level 3.1 requires at least 5 hours of low-intensity treatment services per week, including medication management, recovery skills, relapse prevention, and other similar services. In Level 3.1, the 5 or more hours of clinical services may be provided onsite or in collaboration with an outpatient services agency. Clinically managed low-intensity residential services are designed to improve the patient's ability to structure and organize the tasks of daily living, stabilize and maintain the stability of the individual's substance use disorder symptoms, and to help them develop and apply recovery skills.
Evaluation and Treatment
Patients receive:
- Individual, group, or family therapy, or some combination thereof;
- Medication management;
- Psychoeducation to develop recovery,

- Relapse prevention, and
- Emotional coping techniques.

Treatment should promote personal responsibility and reintegrate the patient to work, school, and family environments. At a minimum, this level of care provides telephone and in-person physician and emergency services 24-hours daily, offers direct affiliations with other levels of care, and is able to arrange necessary lab or pharmacotherapy procedures
Skilled treatment services include:

- Individual, group and family therapy;
- Medication management and medication education;
- Mental health evaluation and treatment;
- Motivational enhancement and engagement strategies;
- Recovery support services;
- Counseling and clinical monitoring;
- MAT; and
- Intensive case management, medication management and/or psychotherapy for individuals with cooccurring mental illness.

ASAM Level 2.1: Intensive Outpatient Programs (IOPs)
IOPs are primarily delivered by substance use disorder outpatient specialty providers but may be delivered in any appropriate setting that meets state licensure or certification requirements. IOPs provide 9–19 hours of weekly structured programming for adults, or 6–19 hours of weekly structured programming for adolescents. Programs may occur during the day or evening, on the weekend, or after school for adolescents. Interdisciplinary teams of appropriately credentialed addiction treatment professionals including counselors, psychologists, social workers, addiction-credentialed physicians, and program staff, many of whom have cross-training to aid in interpreting mental disorders and deliver IOP services. At a minimum, this level of care provides a support system including medical, psychological, psychiatric, laboratory, and toxicology services within 24 hours by telephone or within 72 hours in person. Emergency services are available at all times, and the program should have direct affiliation with more or less intensive care levels and supportive housing. IOP services include:

- Intensive outpatient services including individual and group counseling
- Educational groups
- Occupational and recreational therapy
- Psychotherapy
- MAT
- Motivational interviewing, enhancement and engagement strategies
- Family therapy
- Other skilled treatment services

ASAM Level 1: Outpatient Services (OP)
OP services are appropriate as an initial level of care for patients with less severe disorders; for those who are in early stages of change, as a “step down” from more intensive services; or for those who are stable and for whom ongoing monitoring or disease management is appropriate. Individual or group or family therapy or medication management occurs less than 2 hours/day twice per week

in an ambulatory care setting such as a clinic or office. Depending on organizational policy, services may also be provided in other settings such as school, home or via telemedicine. OP is designed to help patients achieve changes in alcohol and/or drug use and addictive behaviors and often address issues that have the potential to undermine the patient's ability to cope with life tasks without the addictive use of alcohol, other drugs, or both.
OP services may offer several therapies and service components including:

- Individual and group counseling
- Motivational enhancement
- Family therapy
- Educational groups
- Occupational and recreational therapy
- Psychotherapy
- MAT, or;
- Other skilled treatment services.

OPIOID TREATMENT PROGRAMS (OTPS)
Opioid treatment programs (OTPs) provide medication-assisted treatment (MAT) for persons diagnosed with opioid use disorder using any of three FDA-approved medications: methadone, buprenorphine, and naltrexone. OTPs dispense medication and are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT). The duration of treatment, type of medication, and medication dosage should be based on the needs of each person served, and objective withdrawal criteria should be used. Services are directed at improving quality of life and functioning by reducing or eliminating the use of illicit substances (to reduce criminal activity and/or the spread of infectious disease) and fostering vocational skills, family relationships, and community involvement. An OTP must be accredited by a CSAT-approved accrediting body like CARF®. CARF® accredits the majority of OTPs in the United States.

PEER RECOVERY SUPPORT SERVICES
Peer Recovery Support Services and Non-Peer Recovery Support Services are non-clinical services delivered by a Peer Recovery Coach/Certified Recovery Support Worker (CRSW) to help patients and families identify and work toward strategies and goals for supporting, stabilizing and sustaining recovery. A CRSW is required to complete a minimum of the following:

- Thirty (30) hours of approved recovery coach training;
- Sixteen (16) hours of approved ethics training;
- Six (6) hours of approved suicide prevention training; and
- Three (3) hours of approved co-occurring mental health and substance use disorders training.

CRSWs must be supervised by a Master Licensed Alcohol and Drug Counselor (MLADC); a Licensed Alcohol and Drug Counselor (LADC) that is permitted to independently practice; a LADC enrolled under a SUD Outpatient or SUD Comprehensive Medicaid provider type; a LADC who is also a Licensed Clinical Supervisor (LCS); or a licensed mental health provider who has completed the training described above plus an additional six (6) hours of approved training in the supervision of individuals delivering peer recovery support services. With the

exception of peer and non-peer recovery services and continuous recovery monitoring, all services must be consistent with the "Addiction Counseling Competencies, TAP 21".

SUD Peer Recovery Support Services General Requirements

- Group services may only be provided when 2 or more individuals are present.
- Treatment groups are limited to 12 individuals with one counselor present or 16 individuals when that counselor is joined by a CRSW or a second counselor.
- Recovery support groups are limited to 8 individuals with one Peer Recovery Coach/CRSW present or 12 individuals when that Peer Recovery Coach/CRSW is joined by a second Peer Recovery Coach/CRSW.
- All services must be delivered in accordance with the ASAM Criteria. This includes the use of ASAM criteria in admission, continuing care, transfer, and discharge criteria as well as ensuring that services are consistent with the guidelines provided for each level of care.
- All services must be evidence-based, as demonstrated by meeting one of the following criteria:
  - ✓ The service is listed on the SAMHSA Evidence-Based Practices Resource Center site;
  - ✓ The services have been published in a peer-reviewed journal and found to have positive effects; or
  - ✓ The provider can otherwise document the services' effectiveness based on the following:
    - ➢ The service is based on a theoretical perspective that has validated research; or
    - ➢ The service is supported by a documented body of knowledge generated from similar or related services that indicate effectiveness.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage and may not support medical necessity. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (e.g., utilizing immunoassay [e.g., dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (e.g., utilizing immunoassay [e.g.,

CPT® Codes	Description
	EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (e.g., GC, HPLC), and mass spectrometry either with or without chromatography, (e.g., DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832-90840	Psychotherapy
90845-90853	Other psychotherapy
99201-99255	Evaluation and management services
99281-99285	Emergency Department Services
99341-99350	Home services
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

CPT® Codes	Description
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes

HCPCS Codes	Description
G0396	Alcohol and/or substance (other than tobacco) abuse misuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
G0397	Alcohol and/or substance (other than tobacco) abuse misuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed

HCPCS Codes	Description
G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes
H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0003	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs
H0004	Behavioral health counseling and therapy, per 15 minutes
H0005	Alcohol and/or drug services; group counseling by a clinician
H0006	Alcohol and/or drug services; case management
H0007	Alcohol and/or drug services; crisis intervention (outpatient)
H0008	Alcohol and/or drug services; subacute detoxification (hospital inpatient)
H0009	Alcohol and/or drug services; acute detoxification (hospital inpatient)
H0010	Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0012	Alcohol and/or drug services; subacute detoxification (residential addiction program outpatient)
H0013	Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
H0014	Alcohol and/or drug services; ambulatory detoxification

HCPCS Codes	Description
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0021	Alcohol and/or drug training service (for staff and personnel not employed by providers)
H0022	Alcohol and/or drug intervention service (planned facilitation)
H0033	Oral medication administration, direct observation
H0034	Medication training and support, per 15 minutes
H0035	Mental health partial hospitalization, treatment, less than 24 hours
H0047	Alcohol and/or other drug abuse services, not otherwise specified
H0048	Alcohol and/or other drug testing: collection and handling only, specimens other than blood
H0049	Alcohol and/or drug services, brief intervention, per 15 minutes
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H1000	Prenatal care, at-risk assessment
H1001	Prenatal care, at-risk enhanced service; antepartum management
H1002	Prenatal care, at risk enhanced service; care coordination
H1003	Prenatal care, at-risk enhanced service; education
H1004	Prenatal care, at-risk enhanced service; follow-up home visit
H2000	Comprehensive multidisciplinary evaluation
H2010	Comprehensive medication services, per 15 minutes
H2011	Crisis intervention service, per 15 minutes
H2012	Behavioral health day treatment, per hour
H2013	Psychiatric health facility service, per diem
H2017	Psychosocial rehabilitation services, per 15 minutes
H2018	Psychosocial rehabilitation services, per diem
H2025	Ongoing support to maintain employment, per 15 minutes
H2027	Psychoeducational service, per 15 minutes
H2034	Alcohol and/or drug abuse halfway house services, per diem
H2035	Alcohol and/or other drug treatment program, per hour
H2036	Alcohol and/or other drug treatment program, per diem

HCPCS Codes	Description
J0570	Buprenorphine implant, 74.2 mg
J0571	Buprenorphine, oral, 1 mg
J0572	Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine
J0573	Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine
J0574	Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine
J0575	Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine
J2310	Injection, naloxone HCl, per 1 mg
J2315	Injection, naltrexone, depot form, 1 mg
J3411	Injection, thiamine HCl, 100 mg
S0109	Methadone, oral, 5 mg

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
A15.0-A19.9	Tuberculosis
B17.10-B17.11	Acute hepatitis C
B18.2	Chronic viral hepatitis C
B19.20-B19.21	Unspecified viral hepatitis C without hepatic coma Unspecified viral hepatitis C with hepatic coma
B20	Human immunodeficiency virus [HIV] disease
F10.10 - F19.99.	Mental and behavioral disorders due to psychoactive substance use.
O98.711-O98.73	Human immunodeficiency virus [HIV] disease complicating pregnancy
O99.320-O99.325	Drug use complicating pregnancy, childbirth, and the puerperium
T40.0X1+-T40.996+	Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]
T51.0X1+-T51.94X+	Toxic effects of alcohol
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z71.9	Counseling, unspecified

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Rebranded from Corporate policy	4/22	8/14/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

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