Clinical UM Guideline

Subject:	Substance-Related and Addictive Disorder Treatment		
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Description

This document provides medical necessity criteria for levels of care relating to substance and addictive disorders.

There is variation in the availability of services in different geographic and regional areas. If an indicated service is not available within a member's community at the level of service indicated by the criteria, authorization can be given for those services at the next highest available level. Continuing any level of care depends on the persistence of findings that lead to admission as well as attention to the person-centered treatment plan so that as much medical progress as each person's circumstances allow is made toward shared goals.

Treatment of substance use disorders is dependent on a substance use disorder diagnosis based on current (Diagnostic and Statistical Manual of Mental Disorders [DSM-5] or International Classification of Diseases [ICD-10-CM]) criteria.

Note: Please see the following related documents for additional information:

ADMIN.00002 Preventive Health Guidelines

CG-BEH-03 Psychiatric Disorder Treatment

CG-LAB-09 Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain

CG-MED-19 Custodial Care

Clinical Indications

Withdrawal

Inpatient Withdrawal Management (Detoxification)

Medically Necessary:

Severity of Illness Criteria
Assessment of withdrawal risk when multiple types of substance pose a risk of withdrawal should be based on severity risk for each substance type, prioritizing the level of care based on the substance type determined to pose the risk of most severe withdrawal.

Inpatient withdrawal management (detoxification) is considered **medically necessary** when the member has A or B and C:

The member is experiencing signs and symptoms of severe withdrawal, or severe withdrawal is imminent based on history of prior withdrawals, present symptoms and signs, and the member's medical, emotional, behavioral or cognitive condition is incapacitating:

For alcohol: seizures, delirium, psychotic symptoms, the need for intravenous medication or infusions, requires close monitoring due to high levels of agitation, confusion or extremes of vital signs (that is, heart rate greater than 120 beats per minute or temperature greater than 100° F); **or**

For sedative/hypnotics: seizures, delirium, psychotic symptoms and the member has an acute mental or physical disorder that is complicating the withdrawal (such as a heart rate greater than 120 beats per minute or temperature greater than 100° F); **or**

For opioids: the member has a severe withdrawal syndrome (debilitating vomiting and diarrhea, agitation, gross tremor, fever, severe elevation of blood pressure or other signs and symptoms requiring hospital services including electrolyte abnormality such as serum potassium less than 2.5 mEq/L or serum sodium less than 130 mEq/L); **or**

For stimulants: the member has psychotic, impulsive behavior or depressive suicidality that requires hospital care that is a result of stimulant withdrawal; **or**

Hospital care is the only available level of care that can provide the medical support, comfort and care for a pregnant member and withdrawal is complicated by risk of pregnancy complications including but not limited to pre-eclampsia; **and**

Member's clinical condition is of such severity that daily member medical evaluation by a physician or other provider with prescriptive authority is indicated.

Continued Stay Criteria
Inpatient withdrawal management (detoxification) is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurred on each day; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Inpatient withdrawal management (detoxification) is considered **not medically necessary** when the above criteria are not met.

Residential Withdrawal Management (Detoxification) (With 24-hour Nursing)

Medically Necessary:

Severity of Illness Criteria
Assessment of withdrawal risk when multiple types of substance pose a risk of withdrawal should be based on severity risk for each substance type, prioritizing the level of care based on the substance type determined to pose the risk of most severe withdrawal.

Residential withdrawal management (detoxification) (with 24-hour nursing) is considered **medically necessary** when the member has A and B or C:

Member's clinical condition is of such severity that an evaluation by physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**

The member is experiencing signs and symptoms of severe withdrawal, or, based on history of prior withdrawals, present symptoms and signs, and the member's medical, emotional, behavioral or cognitive condition, severe withdrawal is imminent.

For alcohol: severe withdrawal symptoms(use of rating scales such as the Clinical Institute Withdrawal Assessment Alcohol scale revised or CIWA-Ar is encouraged) that are not life threatening; **or**

For sedative/hypnotics: severe anxiety, insomnia, tremor and is able to participate in care; **or**

For opioids: if opioid replacement is not being used, the member has been using opioids daily for over 2 weeks and has a history of not completing withdrawal treatment without medication, or the withdrawal treatment involves induction to an antagonist medication in a brief, intensive (multiday interventions) treatment protocol; **or**

For stimulants: the member has marked lethargy, agitation, paranoia, depression or mild psychotic symptoms due to withdrawals and has poor impulse control and coping skills which make immediate continued drug use likely; **or**

The member requires medication to treat withdrawals and there is a strong likelihood that they will not complete withdrawal management on an outpatient basis as shown by:

The member has recently been treated for withdrawal management at a less intensive level of care and has not been able to complete treatment due to insufficient skills and supports; **or**

The member has a co-occurring medical, mental, emotional, behavioral or cognitive condition that increases the severity of withdrawals and complicates treatment.

Continued Stay Criteria
Residential withdrawal management (detoxification) (with 24-hour nursing) is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Residential withdrawal management (detoxification) (with 24-hour nursing) is considered **not medically necessary** when the above criteria are not met.

Residential Withdrawal Management (Detoxification)

Medically Necessary:

Severity of Illness Criteria
Assessment of withdrawal risk when multiple types of substance pose a risk of withdrawal should be based on severity risk for each substance type, prioritizing the level of care based on the substance type determined to pose the risk of most severe withdrawal.

Residential withdrawal management (detoxification) is considered **medically necessary** when the member has A and B or C:

Member's clinical condition is of such severity that an evaluation by physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**

The member is experiencing signs and symptoms of moderate or mild withdrawal, or, based on history of prior withdrawals, present symptoms and signs, and the member's medical, emotional, behavioral or cognitive condition, moderate or mild withdrawal is imminent AND family, transportation or other supports are not adequate to enable the member to be successfully treated with ambulatory or outpatient withdrawal:

For alcohol: withdrawal symptoms are mild to moderate (use of rating scales like the CIWA-Ar is encouraged); **or**

For sedative/hypnotics: withdrawal symptoms are mild to moderate; **or**

For opioids: the member has withdrawal signs and symptoms that are distressing but do not require medication for reasonable withdrawal discomfort and the member is impulsive and lacks social skills to prevent imminent continued drug use; **or**

For stimulants: the member has marked lethargy, paranoia, or mild psychotic symptoms due to withdrawals and these are still present despite treatment on an ambulatory or intensive outpatient setting; **or**

The member does not require medication for withdrawal treatment, but has inadequate home supervision, support and structure as shown by:

The home situation does not support recovery and has problems that the member does not have the skills to cope with; **or**

The member has recently been treated for withdrawal management at a less intensive level of care and has not been able to complete treatment due to insufficient skills and supports; **or**

The member has recently been treated for withdrawal management at a less intensive level of care and continues to use drugs or alcohol.

Continued Stay Criteria
Residential withdrawal management (detoxification) is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Residential withdrawal management (detoxification) is considered **not medically necessary** when the above criteria are not met.

Substance-Related Outpatient Withdrawal (Detoxification) with Extended On-Site Monitoring

Medically Necessary:

Severity of Illness Criteria
Assessment of withdrawal risk when multiple types of substance pose a risk of withdrawal should be based on severity risk for each substance type, prioritizing the level of care based on the substance type determined to pose the risk of most severe withdrawal.

Substance-related outpatient (detoxification) with extended on-site monitoring is considered **medically necessary** when the member has A or B:

The member is experiencing signs and symptoms of withdrawal, or, based on history of prior withdrawals, present symptoms and signs, and the member's medical, emotional, behavioral or cognitive condition, withdrawal is imminent. The member may be at risk for severe withdrawal syndrome outside of the program, but does not have severe medical or psychiatric complications that would complicate treatment or withdrawals.

For alcohol: mild to moderate withdrawal symptoms (use of rating scales like the CIWA-Ar is encouraged); **or**

For sedative/hypnotics: the member can take substitute medication that has or is likely to treat withdrawals within the time frame of still being at the program site when the medication takes effect; is at minimal risk for severe withdrawal symptoms outside of the hours of the program and does not have a mental or medical disorder that poses a danger to the member outside of the program hours; **or**

For opioids: for treatment not using opioid replacement medication, the withdrawal symptoms can be stabilized by the end of the program hours to the extent that the member can manage

symptoms at home with support and supervision there; for treatment using opioid replacement medication, the withdrawal signs and symptoms are severe enough to require extended monitoring to determine the appropriate dose of the medication; **or**

For stimulants: the member is experiencing significant lethargy, agitation, paranoia, depression or psychotic symptoms such that extended observation is required to determine the level of impulse control and readiness for continued treatment services; **or**

The member is likely to complete withdrawal management as shown by:

The member has support persons who can understand and follow instruction; **or**

The member has an adequate understanding of the treatment proposed and is wants this treatment; **or**

The member has adequate supports to ensure completion of the program and entry into ongoing treatment; **or**

The member is willing to continue treatment once the withdrawal is completed.

Continued Stay Criteria
Substance-related outpatient (detoxification) with extended on-site monitoring is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A or B:

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Substance-related outpatient (detoxification) with extended on-site monitoring is considered **not medically necessary** when the above criteria are not met.

Substance-Related Outpatient Withdrawal (Detoxification) without Extended On-Site Monitoring

Medically Necessary:

Severity of Illness Criteria
Assessment of withdrawal risk when multiple types of substance pose a risk of withdrawal should be based on severity risk for each substance type, prioritizing the level of care based on the substance type determined to pose the risk of most severe withdrawal.

Substance-related outpatient (detoxification) without extended on-site monitoring is considered **medically necessary** when the member has A or B:

The member is experiencing signs and symptoms of mild withdrawal, or, based on history of prior withdrawals, present symptoms and signs, and the member's medical, emotional, behavioral or cognitive condition, withdrawal is imminent. The member is at minimal risk for severe withdrawal syndrome outside of the program:

For alcohol: mild to moderate symptoms of withdrawal (use of rating scales like the CIWA-Ar is encouraged); **or**

For sedative/hypnotics: recent use is at therapeutic doses and is not complicated by concurrent daily use of alcohol or another drug with a potentially severe withdrawal syndrome; withdrawals from this type of drug alone are present and there is evidence or high likelihood that they will respond within 2 hours to a substitute medication; **or**

For opioids: member has not used high-potency (intravenous or intranasal) drugs for the last 2 weeks and drugs used are at or near therapeutic doses; if replacement medication is being used, either this will be tapered gradually, or the withdrawal symptoms are mild; **or**

For stimulants: the member is experiencing some lethargy, paranoia, agitation, depression or mild psychotic symptoms, but has good impulse control; **or**

The member is likely to complete withdrawal management as shown by:

The member has an adequate understanding of the treatment proposed and wants this treatment; **or**

The member has adequate supports to ensure completion of the program and entry into ongoing treatment; **or**

The member is willing to continue treatment once the withdrawal is completed.

Continued Stay Criteria
Substance-related outpatient (detoxification) without extended on-site monitoring is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A or B:

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Substance-related outpatient (detoxification) without extended on-site monitoring is considered **not medically necessary** when the above criteria are not met.

Treatment

Inpatient Treatment (Rehabilitation)

Medically Necessary:

Severity of Illness Criteria
Inpatient treatment (rehabilitation) is considered **medically necessary** when the member no longer meets withdrawal (detoxification) Severity of Illness criteria and when the member has A and B and either C or D:

Member's clinical condition is of such severity that daily member medical evaluation by a physician or other provider with prescriptive authority is indicated; **and**

The member's withdrawal syndrome is not the primary reason for needing this level of care (if it is, the member should be reviewed using withdrawal management level of care criteria); **and**

Severe and unstable medical condition that requires 24 hour medical care as shown by one of the following:

Medical complications of the addictive disorder require this level of medical care; **or**

A concurrent medical condition or pregnancy that requires stabilization with daily medical and nursing care; **or**

A concurrent medical condition or pregnancy in which continued substance use would result in imminent danger to life or health; **or**

Recurrent or multiple seizures; **or**

Experiencing a disulfram-alcohol reaction; **or**

Life threatening symptoms related to the use of the substance(s), such as stupor or convulsions; **or**

Continued substance use is gravely complicating an underlying medical condition; **or**

Worsening of a concurrent medical condition makes abstinence necessary for the member's health and safety; **or**

Significant improvement or stabilization of a medical condition has just been achieved that will allow the start of addiction treatment; **or**

Some medical problem that requires 24-hour observation and evaluation to determine further treatment needs; **or**

Severe and unstable psychiatric condition that requires 24-hour medical care as shown by **one** of the following*:

Emotional, behavioral or cognitive complications of the addictive disorder that requires stabilization with daily medical and nursing care; **or**

A concurrent psychiatric condition that requires stabilization with daily medical and nursing care; **or**

Uncontrolled behavior that poses an imminent danger to self or others; **or**

The member's mental confusion or disorientation poses an imminent danger to the self or others; **or**

A concurrent serious emotional, cognitive or behavioral disorder complicates the treatment of the addictive disorder and requires diagnosis and treatment; **or**

Extreme depression that poses imminent risk of harm to the member; **or**

Impairment in thinking affecting the ability to take care of activities of daily living that poses an imminent risk of harm; **or**

Continued use of substance is causing grave complications or worsening of a concurrent psychiatric disorder; **or**

Altered mental status (not delirium) caused by disorientation to self, alcohol-related hallucinations or toxic psychosis.

*Admission to a hospital that has 24-hour psychiatric specialty medical and nursing services, with both addiction-related and mental health licensed clinicians providing care is clinically most appropriate.

Continued Stay Criteria
Inpatient treatment (rehabilitation) is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurred on each day; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Inpatient treatment (rehabilitation) is considered **not medically necessary** when the above criteria are not met.

Residential Treatment Center with 24-Hour Nursing

Medically Necessary:

Severity of Illness Criteria
Residential treatment center (with 24-hour nursing) is considered **medically necessary** when the member has A, B, and C and one of D, E, F, or G:

Member's clinical condition is of such severity that an evaluation by physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**

The member's withdrawal syndrome is not the primary reason for needing this level of care (if it is, the member should be reviewed using WM level of care criteria); **and**

The member has a medical condition for which the continued use of substances places the member at significant risk of serious damage to their physical health or the member has a medical condition that requires 24-hour nursing and medical care but not the full resources of a hospital; **and**

The member has an emotional, behavioral or cognitive disorder that is moderately severe that requires 24-hour monitoring as shown by one of the following*:

An unstable psychiatric condition or psychiatric decompensation (or a history of decompensation during early stages of recovery) that interferes with abstinence, recovery and stability to such a degree that 24-hour monitoring is necessary for treatment of the addiction; **or**

The member is stressed by recent losses or threatened losses, or by the triggering of past trauma to such a degree that their ability to manage activities of daily living is significantly impaired (such as eating, sleeping or hygiene) and requires a secure, 24-hour medically monitored environment to be able to treat addictive and psychiatric problems; **or**

The member has a co-occurring psychiatric disorder that interferes with addiction treatment and requires medication to stabilize or has recently become stable enough with treatment but the stability is tenuous enough that 24-hour care is required to maintain stability; **or**

The member is severely depressed with suicidal thoughts and/or plan, but is able to seek help and does not require one to one precautions; **or**

The member has significant functional impairment that requires 24-hour psychiatric monitoring; **or**

The member is moderate to high risk for behaviors that would endanger self, others or property likely to result in incarceration, loss of custody of children or imminent danger of relapse with dangerous consequences without 24-hour support and monitoring; **or**

Active intoxication with violent or disruptive behavior that poses an imminent danger to self or others but does not require withdrawal management services to stabilize; **or**

The member is psychiatrically unstable or cognitively impaired enough to require stabilization with 24 hour monitoring; **or**

The member has experienced serious consequences of their addictive disorder but does not accept or relate this to the addictive disorder or the member can only receive intensive motivating strategies or psychiatric stabilization in order to adhere to treatment on a 24-hour medically monitored setting. If the reason for their lack of any commitment to change or appreciate the addiction is due to a mental health disorder, this should be a dual diagnosis program; **or**

The member has one of the following:

Experiencing an acute crisis marked by an intensification of substance use or mental health symptoms that poses a serious risk of harm to self or others without 24-hour monitoring and support; **or**

An escalation or relapse behaviors or re-emergence of acute symptoms that place the member at serious risk of harm to self or others without 24-hour monitoring and support; **or**

The member needs a treatment modality that requires a level of intensity that can only be given at this intensity of service (medication titration for a mental health or medical condition, acute stress disorder treatment, induction of antagonist or agonist medication, etc.); **or**

The member has one of the following:

Current living situation has a high risk of physical, sexual or emotional abuse or of active substance abuse such the member would not be able to achieve or maintain recovery while there; **or**

Family members or other residents of current living situation are not supportive of recovery goals and actively sabotaging treatment or behaving in such a manner that impedes recovery; **or**

The member is unable to cope for even limited periods of time outside of a 24-hour structured setting.

*Admission to a residential facility that has 24-hour psychiatric specialty medical and nursing services, with both addiction-related and mental health licensed clinicians providing care is clinically most appropriate.

Continued Stay Criteria
Residential treatment center (with 24-hour nursing) is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Residential treatment center (with 24-hour nursing) is considered **not medically necessary** when the above criteria are not met.

Residential Treatment Center

Medically Necessary:

Severity of Illness Criteria

Residential treatment center is considered **medically necessary** when the member has all of the following (A-G):

Member's clinical condition is of such severity that an evaluation by physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**

The member has no withdrawal symptoms or if so, can be safely managed at this level of intensity care; **and**

If the member has an active medical condition requiring treatment, it is stable and the member can take medications on their own. If the condition is distracting or interfering with recovery, it can be monitored or managed safely at this level, without 24-hour nursing; **and**

If the member has an active mental health concern, it is either stable or stabilizing, but the member needs 24-hour support and structure for one of the following*:

- The member is unable to control alcohol or drug use, and/or to engage in antisocial behavior that is likely to lead to imminent danger; **or**
- The member is unable to control alcohol or drug use, and/or to engage in antisocial behavior that puts member in imminent danger of relapse that will in turn likely lead to imminent danger; **or**
- The member has a antisocial behavior patterns that has or could lead to significant criminal justice problems, lack of concern for others or extreme lack of regard for authority that precludes participation in a less intensive care setting; **or**
- The member is severely depressed with suicidal thoughts and/or plan, but is able to seek help and does not require one to one precautions; **or**
- The member has significant functional deficits that requires 24-hour rehabilitative care (not medical or psychiatric) that will likely improve the functional deficits; **or**
- The member has a severe personality disorder with behaviors that require continuous boundary setting interventions; **and**

The member has one of the following:

- The member has limited insight and little awareness of their substance use problem and need for treatment; **or**
- The member does not understand the relationship between their addiction and their problems coping or functioning; **or**
- The member actively or passively opposes treatment and continued use of substances poses a danger of harm to self or others; **or**
- Motivational interventions have not succeeded at lower levels of care and there are reasons to think that this would work with 24-hour care; **or**

The member requires repeated, structured clinically delivered motivational enhancement which can only be given with 24-hour care; **or**

The member understands their addiction but has little interest in changing, and continued use is likely to lead to serious life consequences or harm to others; **or**

The member attributes their substance use to others or blames external events and can only get interventions to increase insight with 24-hour care; **and**

The member has one of the following:

The member does not recognize relapse triggers and lacks insight into the need for treatment. Continued substance use poses an imminent danger of harm to self or others; **or**

The member has a mental health disorder which is stabilizing but the member is unable to stop use of substances and continued use poses an imminent danger of harm to self or others; **or**

The member has craving, immediate gratification or drug seeking behavior and continued use poses an imminent danger of harm to self without 24-hour care; **or**

The member is in a crisis situation that is causing an imminent danger of relapse or continued use with dangerous consequences; **or**

The member has been in treatment at a lower level but continues to use or deteriorate with their mental disorder and is at high risk for continued deterioration; **or**

The member has had repeated incarcerations followed by relapses with substances, and this poses an imminent risk of harm to self or others; **and**

The member has one of the following:

The member lives in an environment where there is neglect, physical/sexual or emotional abuse, or pervasive substance use such that recovery is unlikely while the member resides there; **or**

The member's social network is made up of substance users such that achieving recovery is not considered likely at a lower level of care; **or**

The member is isolated or withdrawn so much that achieving recovery is not considered likely at a lower level of care; **or**

The member lives with a person who is an addict or dealer of substances and the home environment is so highly invested in substance use that recovery while living there is unlikely; **or**

The member is unable to cope with their environment without 24-hour care; they are likely to be able to cope with treatment.

Continued Stay Criteria

Residential treatment center is be considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Residential treatment center is considered **not medically necessary** when the above criteria are not met.

Low Intensity Residential with Clinical Services

Medically Necessary:

Severity of Illness Criteria
Low intensity residential with clinical services is considered **medically necessary** when member has all of the following (A-G):

Member's clinical condition is of such severity that a psychiatric evaluation by a physician or other provider with prescriptive authority is indicated at admission; **and**

The member has no withdrawal symptoms or if so, can be safely managed at this level of intensity care; **and**

If the member has an active medical condition requiring treatment, it is stable and the member can take medications on their own. If the condition is distracting or interfering with recovery, it can be monitored or managed safely at this level, without 24-hour nursing; **and**

The member has emotional, behavioral or cognitive problems or functional limitations in the context of their home environment that are severe enough that the member is not likely to maintain stability or abstinence without 24-hour care; **and**

The member has one of the following:

The member accepts that they have a substance use or mental disorder and recognizes adverse consequences and is ready to change; **or**

The member is at early stages of readiness to change and is engaged in outpatient or intensive outpatient program services while staying in the group home/halfway house; **or**

The member has failed previous motivational interventions and needs 24-hour support to support progress in treatment and recovery; **or**

The member attributes their substance use to others or blames external events and can only get interventions to increase insight with 24-hour care; **and**

The member has one of the following:

The member has limited coping skills to address relapse triggers and lacks insight into the need for treatment. Continued substance use poses an imminent danger of harm to self or others; **or**

The member understands that they have a substance use or mental health disorder but is at risk of relapse outside 24-hour care because they cannot consistently address this; **or**

The member needs consistent staff support to maintain engagement in recovery treatment while making a transition to living in the community; **or**

The member is at high risk of substance use or deteriorated mental functioning with dangerous consequences without 24-hour structured support and the member is addressing this in an intensive outpatient program (IOP) while residing in the group home/halfway house; **and**

The member is able to cope outside of this setting for limited times in order to pursue clinical, educational, vocational or other community activities and has one of the following:

The member lives in an environment where there is a moderately high risk of neglect, physical/sexual or emotional abuse, or pervasive substance use such that recovery is unlikely while the member resides there; **or**

The member either has social isolation or has high risk social contacts who are regular substance users such that achieving recovery is not considered likely at a lower level of care; **or**

The member lives in a home environment is so highly invested in substance use that recovery while living there is unlikely; **or**

Continued exposure to the school, home or work environment makes recovery unlikely, or the member lacks resources to maintain adequate functioning outside of a 24-hour support program; **or**

The member is in danger of victimization by someone without 24-hour supervision.

Continued Stay Criteria

Low intensity residential with clinical services is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs in response to treatment issues such as medication effectiveness, side effects and other medical problems; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Low intensity residential with clinical services is considered **not medically necessary** when the above criteria are not met.

Partial Hospitalization Program

Medically Necessary:

Severity of Illness Criteria
Partial hospitalization program is considered **medically necessary** for a direct admission when the member has A and B or C and one of D-F:

Member's clinical condition is of such severity that an evaluation by a physician or other provider with prescriptive authority is indicated at admission and weekly thereafter; **and**

The member has a medical condition or problem that is severe enough to distract from recovery efforts that requires medical monitoring and management which can be provided with this intensity of service; **or**

The member has one of the following:

A history of having had mild to moderate psychiatric decompensation after discontinuing a drug or alcohol in the past; requires monitoring to intervene if this occurs; **or**

Current inability to maintain behavioral stability over a 48-hour period; **or**

Mild to moderate risk of behaviors that could endanger self, others or property and imminent risk of relapse with dangerous consequences without this level of structure; **and**

Motivational interventions have been tried and failed at a lower level of care, or, due to the member's perspective and impulse control, motivational interventions need to be frequent and repeated with more structure than that available at a lower level of care. If the member has a mental disorder that contributes to this, and the member has little or no awareness of this and they need more intensive services to maintain an adequate level of functioning; **or**

The member has been in treatment at a lower level of care and has had an intensification of symptoms that is causing a deterioration in level of functioning even with a modification of the treatment plan, or, the member has attempted treatment or is in treatment at a less intensive level and is likely to continue to use or relapse due to a lack of awareness of triggers, ambivalence toward treatment or difficulty coping and deferring gratification; **or**

The member is unlikely to be able to function adequately and achieve recovery with continued exposure to current living environment, school or work, or, family members or people in living environment are not supportive of recovery and are passively opposed to treatment; member needs relief from this environment but can still live there.

Continued Stay Criteria
Partial hospitalization program is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs weekly; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Partial hospitalization program is considered **not medically necessary** when the above criteria are not met.

Intensive Outpatient Program

Medically Necessary:

Severity of Illness Criteria
Intensive outpatient program is considered **medically necessary** when the member has A and one of B-D:

Member's clinical condition is of such severity that a psychiatric evaluation by a physician or other provider with prescriptive authority is indicated at admission; **and**

The member's perspective on their substance use inhibits their ability to make behavioral changes without repeated, structured, clinically directed motivational interventions. If this is due to a mental disorder, there is either limited awareness or acceptance of this or the member is not likely to follow up with regular outpatient care; **or**

The member has one of the following:

The member has been getting outpatient treatment but there has been an intensification of symptoms or deterioration of functioning that has not improved despite changes to the treatment plan; **or**

The member is not aware of relapse triggers and is highly like to continue using or relapse without close monitoring and structured services; **or**

The member has one of the following:

Continued exposure to the current school, work or living environment makes recovery unlikely and the member lacks skills to cope with this without the support of a structured program; **or**

The member either lacks social supports or has unsupportive social contacts and those who use substances and lacks the skills to cope with this without the support of a structured program.

Continued Stay Criteria
Intensive outpatient program is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A and B or C:

Member evaluation by a physician or other provider with prescriptive authority occurs in response to treatment issues such as medication effectiveness, side effects, and other medical problems; **and**

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Intensive outpatient program is considered **not medically necessary** when the above criteria are not met.

Outpatient Treatment

Medically Necessary:

Severity of Illness Criteria
Outpatient treatment is considered **medically necessary** when the member has all of the following (A-D):

Substance use is excessive, maladaptive and two (2) symptoms have been present within a 12-month period; **and**

There is evidence that the member is motivated as evidenced by expression of an interest or desire to work towards the goals of treatment recovery or can be motivated; **and**

Member's social system and significant others are supportive of recovery, or member demonstrates the social and cognitive skills to develop a sober support system; **and**

Member does not meet the criteria for a higher level of care.

Continued Stay Criteria
Outpatient treatment is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A or B:

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Outpatient treatment is considered **not medically necessary** when the above criteria are not met.

Outpatient (Office Based) Medication Assisted Treatment (MAT) of Opioid Use Disorder

Medically Necessary:

Severity of Illness Criteria
Outpatient (office-based) medication assisted treatment (MAT) of opioid use disorder is considered **medically necessary** when the member has all of the following (A-G):

There is a reasonable expectation of compliance; **and**

There is evidence that the member has restorative potential. This will be demonstrated in part, although not limited to, member's expression of an interest or desire to work towards the goals of treatment and recovery, including abstinence from all illicit substance use and all opioid use; **and**

Member's social system and significant others are supportive of recovery, or member demonstrates the social and cognitive skills to develop a sober support system; **and**

There is documentation of the absence of current, active untreated use of alcohol, sedative-hypnotics or other central nervous system depressants; **and**

If the member is pregnant, the program physician should verify the pregnancy and the obstetrician or other provider managing the pregnancy has been consulted and care concurs with the treatment plan before MAT is initiated; **and**

The member is not acutely psychotic, imminently suicidal, or imminently homicidal; **and**

The member gives permission for free exchange of clinical information among all health care providers, including pharmacists.

Continued Stay Criteria
Outpatient (office-based) medication assisted treatment (MAT) of opioid dependence is considered **medically necessary** when the member continues to meet Severity of Illness criteria and has A or B:

Progress with the withdrawal symptoms and behaviors is documented and the member is sufficiently cooperative with treatment plan to meet goals; **or**

If progress is not occurring, then the treatment plan is being re-evaluated and amended with goals that are still achievable.

Not Medically Necessary:

Outpatient (office-based) medication assisted treatment (MAT) of opioid dependence is considered **not medically necessary** when the above criteria are not met.

Coding

Coding edits for medical necessity review are not implemented for this guideline. Where a more specific policy or guideline exists, that document will take precedence and may include specific coding edits and/or instructions. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at

the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Discussion/General Information

The illnesses associated with substance-related and addictive disorder treatment can be roughly grouped into intoxication, withdrawal and rehabilitation. Intoxication with a substance like alcohol can be lethal, perhaps especially at first exposure, and often complicates medical and behavioral health treatment for other conditions (trauma and depression are examples). For most addictive substances, intoxication is relatively brief (lasting hours). Management of withdrawal and treatment of substance related disorders are the reasons that members seek the types of care covered in this guideline.

The management of withdrawal syndromes, also referred to as detoxification, depends in part on the type of substance. The duration and intensity of use also contribute. Concomitant medical conditions, often reflecting the impact of the substance used, are another factor in the type of care needed. Alcohol withdrawal is the most common and, arguably, most varied type of withdrawal syndrome. Thiamine administration is advisable, especially in hospital and residential settings. In the most severe instances, associated with the well-known medical term delirium tremens, intensive care unit (ICU) treatment with life support measures and management of psychosis is required. This type of medical treatment falls under the expertise of medical practitioners who manage care in ICUs and is outside the realm of this guideline. At the other end of the spectrum of severity, mild alcohol withdrawal can be managed with office care in supportive outpatient settings.

Treatment of addiction, also often referred to as rehabilitation, can also be provided in a wide variety of settings. Many treatment settings incorporate community resources in the patient-centered care plan; at least some individuals use community resources as the sole means of addressing addiction. For some individuals, starting treatment for a substance-related disorder requires the restrictive environment of the hospital to manage serious psychiatric symptoms like suicidality or poorly controlled medical conditions like diabetes.

At each level of care, different facilities and programs offer and provide different services. However, common features should exist across all levels of care. For example, all levels of care should coordinate care with other clinicians, such as the outpatient psychiatrist, therapist, and the member's primary care physician, providing treatment to the member. Coordination of care is also useful when clinicians provide treatment to others such as family members. Treatment should be individualized rather than determined by a programmatic time frame. The programming should be consistent with the member's language, cognitive, speech and/or hearing abilities. If medication is being used it should be documented what is being used. If medication is not being used when an indication exists, there should be documentation as to why it is not being used. Discharge planning should be in place across all levels of care including identification of the range of community/family resources. Medication reconciliation is a critical component of all care transitions, especially hospital discharge.

The staff at each level of care should be able to provide care that is appropriate to the clinical needs of each member receiving treatment. The staff members should be properly licensed to provide the treatment requested. At the inpatient level, a physician directs and coordinates care and can visit at least daily, 7 days per week. In a residential treatment center, an evaluation should be done by a qualified physician within 48 hours, and physical exam and lab tests should be completed unless done prior to admission. Skilled nursing care (either by a registered nurse or licensed vocational/licensed practical nurse) must be available on-site for at least 8 hours daily with 24 hour medical availability to manage medical problems if medical instability is identified as a reason for admission to this level of care. In a residential treatment center there should be individual treatment with a qualified physician at least once a week including medication management if indicated and individual treatment with a licensed behavioral health clinician at least once a week. Low intensity residential services are generally configured like intensive outpatient services. In a partial hospitalization program, programs operate under the direction of a physician and a program leader. The

physician provides supervision of the clinical needs of the members enrolled in the program and the program leader is responsible for the overall clinical and administrative operations of the program. Physicians should have face to face contact on admission for an evaluation and thereafter as clinically indicated, at least one time a week. Coordination of care with the member's primary care provider must take place in any situation where there are medical comorbidities. A member of the clinical staff serves in a case management capacity to coordinate the member's treatment within the program and works consistently with the member (and family as indicated) and follows the course of clinical treatment from admission through discharge. Physicians need to be available for consultation with other staff and for face to face evaluations with members during program hours or available 24 hours a day, 7 days a week by telephone outside of program hours. Staff members must possess appropriate academic degrees, licensure, or certification as well as experience with the particular populations treated as defined by program function and applicable state regulations. Core clinical staff members may include: psychiatrists, psychologists, social workers, counselors, addiction counselors, medical and nursing personnel. Occupational, recreational and creative arts therapists may also provide services. Paraprofessionals, non-degreed individuals, students and interns may be included. In an intensive outpatient program, a psychiatric evaluation by a physician should be done by the third day of attendance (unless stepping down from a higher level of care) and thereafter as needed. For medication management, a qualified physician, psychiatric nurse practitioner (or physician extender or independently licensed clinician as permitted by law or health plan benefits) as appropriate prescribes the medication.

There are also distinct differences between facilities and programs in other types of services provided. At the inpatient withdrawal level of care there should be a multidisciplinary assessment with a person-centered treatment plan addressing nutritional, psychological, social, medical, substance abuse, and aftercare needs. Relevant medical tests including lab tests (urine or, rarely, blood drug screen) may be done on admission and follow-up tests done for any abnormality requiring intervention. Medication management of withdrawal symptoms should be tailored to the member's individual needs and there should be documentation of rationale if no medication is being used. At the inpatient treatment level of care, the programming provided should be consistent with the member's language, cognitive, speech and/or hearing abilities. There should be an implementation of an individualized, problem-focused treatment plan which may include the completion of a personal substance abuse history with acknowledgement of consequences of use, provisions for member to access psychiatric treatment as needed for a dual diagnosis, initiation or continuation of relapse/recovery program with identification of relapse triggers, supervised attendance at community-based recovery programs when appropriate and available, drug screens as clinically appropriate and at random, and family program and involvement in treatment, as appropriate. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated.

During the admission process, members at risk for substance withdrawal can be identified by gathering information about the following; is there a history of alcohol or other substance withdrawal, has there been delirium tremens or withdrawal seizures, what is the number of alcoholic beverages consumed each day or is there significant regular use of other psychoactive substances, are there any concurrent clinically significant abnormalities related to substance abuse. Gathering this information and placing these at-risk members into low-stimulation, monitored environments and providing appropriate pharmacologic prophylaxis can assist the withdrawal process.

While in the hospital, the evaluation of accompanying medical and/or psychiatric conditions may become necessary including, laboratory testing (for example, pregnancy test, electrolytes, complete blood count, liver function studies, toxicology screens), imaging studies such as computed axial tomography (CAT) scan or magnetic resonance imaging (especially of the head), lumbar puncture, electroencephalogram (in the case of seizures), and medical or psychiatric consults. Treatment can include medication, intravenous hydration, counselling, involvement of parents (if the member is a child or adolescent), and an intensive care unit stay.

In a residential treatment center, at the withdrawal and treatment levels of care (either with or without 24-hour nursing), there should be documentation of drug screen results upon admission or physical exam and lab tests done within 48 hours if not done prior to admission. There should be a multi-disciplinary problem-focused

treatment plan that addresses psychological, social (including living situation and support system), medical, substance abuse and treatment (rehabilitation) needs which is re-evaluated and amended in a timely and medically appropriate manner as indicated. Family supports should be identified and contacted within 48 hours and family/primary support person participation in treatment at least weekly unless contraindicated. For adolescents, this includes weekly individual family therapy, unless clinically contraindicated. The treatment would include the following at least once per day, with each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy. There should be an evaluation for medication that may improve the member's ability to remain abstinent or reduce substance use in a clinically meaningful way. If no medication is being prescribed, there should be documentation of the reason why it is not being used. Drug screens can be used after all off-grounds activities and whenever otherwise indicated. In the low intensity residential with clinical services, the addition of treatment would include program activities at least 5 hours per week of professionally directed treatment.

In the substance-related outpatient withdrawal with extended on-site level of care, the withdrawal should be conducted in a medical facility (that is, hospital or medical clinic) to determine the need for more or less intensive withdrawal (detoxification) services. The withdrawal (detoxification) is conducted in a facility that is fully integrated with intensive outpatient or partial hospital substance abuse treatment (rehabilitation) services. There should be documentation of drug screen results upon admission and as clinically indicated. A multi-disciplinary problem-focused treatment plan should be in place that addresses psychological, social (including living situation and support system), medical, substance abuse and treatment (rehabilitation) needs. An addiction-focused history should be obtained as part of the initial assessment and reviewed by the physician during the admission process. If there is not extended on-site monitoring, the withdrawal can take place in a health care facility such as a physician's office, hospital outpatient department, mental health treatment facility or addiction treatment facility. The withdrawal should be managed by a physician, who assesses the member each day that withdrawal (detoxification) services are provided, and who provides for 24-hour emergency coverage during withdrawal (detoxification). In cases of opioid substitution methods of withdrawal (detoxification), the withdrawal is managed by a physician authorized by the Drug Enforcement Administration (DEA) to use opioids for withdrawal (detoxification). An addiction-focused history should be obtai
ned as part of the initial assessment and reviewed by the physician during the admission process. Appropriate laboratory and toxicology tests should be performed. A problem-focused treatment plan should be in place that addresses psychological, social (including living situation and support system), medical, substance abuse and treatment (rehabilitation) needs. There should be a daily assessment of progress during withdrawal (detoxification) and any treatment changes (or less frequent if the severity of withdrawal is documented to be sufficiently mild or stable).

In a partial hospitalization program, multidisciplinary treatment should be provided at least 6 hours a day (unless defined differently by local state law). The frequency of attendance per week may vary according to clinical needs and progress, a minimum number of 4 or 5 times per week. Nursing and physician treatment should be documented if needed as evidenced by acute medical or psychiatric interventions being listed on the treatment plan. The programming provided should be consistent with the member's language, cognitive, speech and/or hearing abilities. An individualized treatment plan should be implemented with anticipated dates of completion that are tied to the member's needs, not a fixed program schedule, and can include:

Completion of a personal substance abuse history with acknowledgement of consequences of use.

Initiation or continuation of relapse/recovery program with identification of relapse triggers.

Goal of attendance at community-based recovery programs-to be attended at least 2 times per week or documented rationale as to why this should not be required.

Drug screens are obtained on a random basis with evidence of an adjustment to the treatment plan if results are positive.

Family involvement in treatment as appropriate. For adolescents this should include individual family sessions at least 1 time each week, unless clinically contraindicated.

If a behavioral health diagnosis is present requiring active treatment or the facility is providing dual diagnosis services, qualified physician visits should be documented as necessary. There should be an evaluation for medication that may improve the member's ability to remain abstinent or reduce substance use in a clinically meaningful way and there should be documentation of rationale if no medication is prescribed. The member should reside in a community setting while receiving partial hospitalization services and is not in a 24-hour residential treatment setting. The treatment would include the following at least once a day with each lasting 60-90 minutes: community/milieu group therapy, group psychotherapy, and activity group therapy.

In an intensive outpatient program, treatment services should be offered at least 3 treatment hours per day, at least 3 times per week. The programming provided should be consistent with the member's language, cognitive, speech and/or hearing abilities. Implementation of an individualized, problem-focused treatment plan should include:

Completion of personal substance abuse history with acknowledgment of consequences of use.

Initiation or continuation of relapse/recovery program with identification of relapse triggers.

Attendance at community-based recovery programs - to be attended at least 3 times per week.

Drug screens as clinically appropriate and at random and an intervention plan to address drug use while in treatment.

Family program and involvement in treatment as appropriate. For adolescents, at least 1 time each week, unless clinically contraindicated.

The program has provisions for member to access psychiatric treatment for a dual diagnosis, as needed.

The member should reside in a community setting while receiving intensive outpatient program services and is not in a 24-hour residential treatment setting. There should be an evaluation for medication that may improve the member's ability to remain abstinent or reduce substance use in a clinically meaningful way and there should be documentation of rationale if no medication is prescribed.

In outpatient treatment, individualized therapy in conjunction with community based programs and frequency of visits should be decreased over time to generally less than 1 time per week. There should be documentation of complete drug and alcohol assessment, an assessment of family and social support system, and an individual treatment plan which includes:

Identification of recovery goals.

Issues such as mental preoccupation with alcohol or drug use, cravings, peer pressure, lifestyle, consequences of use, and attitudinal changes are addressed.

Development of a relapse prevention plan and sober support system.

Monitoring attendance at community-based recovery programs.

Utilization of educational materials (books, videos).

Drug screens as clinically appropriate (may require coordination with a physician).

Development of a discharge/aftercare plan.

Referred to psychiatric services for a dual diagnosis, as needed.

There should be an evaluation for medication that may improve the member's ability to remain abstinent or reduce substance use in a clinically meaningful way and there should be documentation of rationale if no medication is prescribed.

In an outpatient (office-based) medication assisted treatment (MAT) for opioid use disorder, treatment should conform to the requirements of Federal regulations such as The Drug Addiction Treatment Act of 2000 (DATA 2000):

MAT is managed by a physician who has been granted a waiver from the special registration requirements in the Controlled Substances Act to provide opioid addiction therapy with approved Schedule III, IV, or V narcotics.

Only indicated Schedule II, III, IV, or V narcotics are utilized.

The physician assesses the member face-to-face on each day that MAT services are provided, and provides for 24-hour emergency coverage during MAT. Support should be provided by a program counselor qualified by education, training, or experience to assess the psychological and sociological background of individuals receiving treatment. There should be a face-to-face assessment at least monthly by the prescribing physician. A psychiatric consultation should be completed within the first 30 days for any member with a current diagnosis (DSM-5 or ICD-10 CM) which may interfere with recovery. An assessment of family and social support system should occur within the first week of treatment. Individual treatment plan should include:

Psychosocial components of treatment by licensed or certified substance abuse and/or behavioral health providers at intervals appropriate to the stage of recovery. The psychosocial component of treatment may also be provided by a physician who has the appropriate training and experience to provide such treatment.

Management of impediments to recovery including interpersonal, legal, financial and housing.

Tapering of MAT in a manner that is medically appropriate for discontinuation of all opioids (unless treatment is for maintenance).

Monitoring attendance at community-based recovery programs.

Utilization of educational materials (books, videos).

Monitoring of adherence using drug screening, pill counts or both.

Development of a discharge/aftercare plan.

Referral to psychiatric services for a dual diagnosis, as needed.

There should be an evaluation for other types of medication that may improve the member's ability to remain abstinent and there should be documentation of rationale if no medication is prescribed.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has updated Opioid Treatment Program guidelines that are based on Federal Regulations in 2015. The regulations and guideline set standards that may be applicable beyond medical necessity decisions based on this guideline. For example, the guideline indicates that, prior to an admission to a treatment program, the individual is currently addicted to an opioid drug and has been addicted for at least 12 months and has had two or more unsuccessful detox attempt in that 12 month period. Individuals under 18 years of age may have additional admission requirements (SAMHSA, 2015 [42 CFR 8.12(e)]) and special populations such as pregnant women. In addition, opioid treatment programs need to provide at least eight random drug abuse tests per year (SAMSHSA, 2015 [42 CFR § 8.12(f)(6)]). Provision for administration of take-home medications should be in place to limit the potential for opioid agonist treatment medications to be used illicitly (SAMHSA, 2015 [42 CFR § 8.12 (h) (4)]).

Diagnosis of substance-related and addictive disorders is principally based on American Psychiatric Association criteria (DMS-5). The American Society of Addiction Medicine (ASAM) provides extensive guidance on the use of treatment resources to manage substance related withdrawal and addiction treatment.

Substance-related disorder treatment should not be primarily for the avoidance of incarceration of the member or to satisfy a programmatic length of stay (refers to a pre-determined number of days or visits for a program's length instead of an individualized determination of how long a member needs to be in that program). There should be a reasonable expectation that the member's illness, condition, or level of functioning will be stabilized, improved, or maintained through treatment known to be effective for the member's illness.

It is noted that there is variation in the availability of services in different geographic and regional areas. If an indicated service is not available within a member's community at the level of service indicated by the criteria, authorization may be given for those services at the next highest available level.

In some geographical areas, state regulations allow non-physicians to treat members at inpatient facilities. In these documents, such non-physicians with prescriptive authority who are operating within the scope of their license may be substituted where the criteria specifies a physician.

Definitions

Inpatient Withdrawal Management (Detoxification): Substance use withdrawal management directed by physicians in a 24 hour per day care setting licensed as a hospital.

Residential Withdrawal Management (Detoxification) (With 24-hour Nursing): Twenty-four (24) hours per day specialized withdrawal management involving at least of one physician visit per week in a facility-based setting.

Residential Withdrawal Management (Detoxification): Twenty-four (24) hours per day specialized withdrawal management involving one physician visit per week in a facility-based setting.

Substance-Related Outpatient Withdrawal (Detoxification) with Extended On-Site Monitoring: Physician-guided withdrawal management in locations such as a daytime service setting. Around-the-clock care would not be necessary.

Substance-Related Outpatient Withdrawal (Detoxification) without Extended On-Site Monitoring: Clinician-guided scheduled outpatient withdrawal management in multiple types of settings. Around-the-clock care would not be necessary.

Inpatient Treatment (Rehabilitation): Substance use disorder treatment directed by physicians in a 24-hour per day care setting licensed as a hospital.

Residential Treatment Center with 24-Hour Nursing: Twenty-four (24) hours per day specialized treatment involving at least one physician visit per week in a facility-based setting.

Residential Treatment Center: Twenty-four (24) hours per day specialized treatment involving at least one physician visit per week in a facility-based setting.

Low Intensity Residential with Clinical Services: Clinician-directed 24 hours per day specialized treatment in a facility-based setting.

Partial Hospitalization Program: Structured, short-term outpatient treatment that offers nursing care and active treatment in a program that operates 6 hours per day, 5 days per week. Around-the-clock care would not be necessary.

Intensive Outpatient Program: Structured treatment that includes a combination of individual, group and family therapy in a treatment plan for members living in the community with problems responsive to a facility-based program of care delivered a few hours a day.

Outpatient Treatment: A behavioral health professional licensed to practice independently provides care to individuals in an outpatient, often an office, setting. Around-the-clock care would not be necessary.

Outpatient (Office Based) Medication Assisted Treatment (MAT) of Opioid Use Disorder: Use of medications by appropriately licensed practitioners to treat opioid use disorders in outpatient settings. Around-the-clock care would not be necessary.

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History

Status	Date	Action
Reviewed	02/27/2018	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	02/23/2018	Behavioral Health Subcommittee review. The document header wording updated from “Current Effective Date” to “Publish Date.” Updated References section.
Reviewed	02/02/2017	MPTAC review.
Reviewed	01/20/2017	Behavioral Health Subcommittee review. Updated formatting in Clinical Indications section. Incorporation of service descriptions that take into consideration a member’s medical needs. Updated Discussion/General Information and References sections.
	11/07/2016	Updated Definition for Intensive Outpatient Program.
Revised	02/04/2016	MPTAC review.
Revised	01/29/2016	Behavioral Health Subcommittee review. Addition of heart rate criteria to Medically Necessary Statements. Updated Discussion/General Information, Definition and Reference sections.

Revised	08/06/2015	MPTAC review.
Revised	07/31/2015	Behavioral Health Subcommittee review. Service Expectations indications moved to Discussion/General Information. Updated References.
Revised	05/07/2015	MPTAC review.
Revised	04/30/2015	Behavioral Health Subcommittee review. Updated Description, Definitions, and References. Multiple clarifications to Clinical Indications.
Revised	08/14/2014	MPTAC review.
Revised	08/08/2014	Behavioral Health Subcommittee review. Title change to "Substance-Related and Addictive Disorder Treatment." Updated Description, Discussion/General Information, References, and Index. Multiple changes to the Clinical Indications.
Revised	02/13/2014	MPTAC review.
Revised	02/07/2014	Behavioral Health Subcommittee review. Removed indications of Axis from Clinical Indications.
New	08/08/2013	MPTAC review.
New	07/26/2013	Behavioral Health Subcommittee review. Initial document development. Clarification to Clinical Indications Partial Hospitalization Program, Intensity of Service. Updated References. The Behavioral Health Medical Necessity Criteria effective January 1, 2013 was split apart into specific subject matter clinical UM guidelines.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to adopt a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.