Clinical Policy: Substance Use Disorder

Reference Number: CP.BH.100 Coding Implications
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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 Cenpatico Behavioral Health (CBH) for the Medicaid, Medicare, and Marketplace lines of business. This clinical policy outlines the management of substance use disorder treatment within the Centene Corporation.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® and CBH to utilize Level of Care Guidelines (ASAM) that outline objective and evidence- based criteria to standardize coverage determinations and utilization management (UM) practices whose BH UM function has been delegated to CBH.
   A. The ASAM Substance Use Disorder (SUD) Criterial are designed for patients 13 years of age and older presenting with a predominant symptom of SUD.

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. Centene's policy on substance use treatment is based on the best current evidence for treatment that supports recovery. The basic 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 first.
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 now considered standard of care for substance use disorder treatment. This type of treatment falls into two broad categories:

A. Medications used to support abstinence and recovery maintenance.

B. Medications used to manage withdrawal or intoxication.

Categories of medication used to support abstinence and recovery:

a. Antagonist medications e.g. naltrexone/Vivitrol®

b. Agonist medications e.g. methadone, nicotine replacement therapies.

c. Partial agonist medications e.g. Buprenorphine, Varenicline®

d. Aversive agents such as Disulfiram (Antabuse®)

e. Novel treatments/alternative mechanisms of action/off-label use: e.g. (Gabapentin & Baclofen for alcohol use disorders), Buproprion (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-R 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

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

Opioid Withdrawal Protocols:

a. Using opioid substitution:

- Buprenorphine
- Methadone

b. 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:

a. Using benzodiazepine substitution

b. Using phenobarbital substitution

c. Using anticonvulsants meds (gabapentin, carbamazepine)

d. 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:

a. Using phenobarbital substitution

b. Using clonazepam substitution

c. Using other 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 the Rehabilitation Phase of 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. 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.
  - 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 for:
  - Opioids: This should be offered as part of the treatment planning options to opioid use disorder patients who have repeatedly failed to sustain abstinence despite prior completion of rehabilitation treatment.
    - 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.

All these drug classes should be covered at parity with treatments for other medical conditions. "Fail-first" policies with regards to MAT are not considered standard of care and are not recommended.

Additional MAT Considerations

1. ***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.

2. ***Long Acting Drug Formulations***:

   There now exist several long – acting formulations of drugs used for MAT. These include
   i. Long acting injectable naltrexone (Vivitrol®)
   ii. Long acting injectable buprenorphine (Sublocade®).
   iii. 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.

3. ***MAT in Special Populations:***
   a. Pregnancy
   b. Adolescents
   c. Reentry populations
   d. 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.

4. ***"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
    a. People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatment planning sessions;
    b. Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
    c. Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
    d. 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.

ASAM guidelines will be applied upon admission to, assessment of need for continued care, and discharge from each level of care.

Historically, addiction treatment has relied heavily on episodic treatment, such as inpatient withdrawal and 30-day rehabilitation with variable adherence to best practices.[2] Since SUDs are chronic, relapsing disorders with a highly 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. When paired with MAT, counseling, psychosocial treatments and attention to social determinants, ambulatory treatment at ASAM levels 1 through 2.5 can be as, or more, effective than more intensive treatment at higher ASAM levels.

Centene's Level of Care Guidelines outline objective and evidence-based criteria to standardize coverage determinations and utilization management (UM) practices for Centene-affiliated health plans whose BH UM function has been delegated to Centene Behavioral Health.
The Substance use Disorders (SUD) Criteria are designed for patients **13 years of age and older presenting with a predominant symptom of a SUD.**

[1] https://missouriopioidstr.org/updates/2018/9/13/medication-first-model-1-pager
[2] https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice

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

INPATIENT (IP) – Level 4 ASAM

Introduction

- The IP criteria are used for a patient who has been or is expected to be admitted to an inpatient unit and requires acute medical or psychiatric treatment 24 hours/day for a medical issues, severe psychiatric diagnoses or complex SUD.
- Inpatient refers to acute psychiatric or medical treatment in an acute care or psychiatric hospital inpatient unit and is considered a Level 4 service by ASAM.
- Treatment is provided 24 hours/day, 7 days/week under the direction of a physician.
- IP is recommended for patients who are in acute danger to themselves or others, or unable to provide required self-care and lack available support.

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 1x/day
- 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

INPATIENT WITHDRAWAL – Level 4 ASAM

Introduction

- The IP 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.
- Inpatient refers to intensive IP treatment in an acute or psychiatric SUD IP hospital unit and is considered a Level 4 service by ASAM.

- IP withdrawal is provided 24 hours/day, 7 days/week nursing care under the direction of a physician.
- IP withdrawal is recommended for patients with unstable and severe SUD who require 24 hours/day medically managed withdrawal services. The main focus is to stabilize the patient in order to safely transfer to a less intensive 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 meds:

Opioid Withdrawal Protocols:

a. Using opioid substitution:
   - Buprenorphine
   - Methadone
   - Other opioids
b. Using clonidine

Alcohol Withdrawal Protocols:

a. Using benzodiazepine substitution
b. Using phenobarbital substitution
c. Using anticonvulsants meds (gabapentin, carbamazepine)

Sedative-Hypnotics Withdrawal Protocols:

a. Using phenobarbital substitution
b. Using clonazepam substitution
c. Using other benzodiazepine substitution.
d. 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
- 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

INPATIENT REHAB – Level 3.7 ASAM

Introduction

- The IP Rehabilitation criteria is used for a patient who has been or is expected to be admitted to a hospital based IP rehabilitation program and requires 24 hour nursing/medical monitoring under the direction of a physician as part of a psychotherapeutic program.
- Inpatient rehabilitation is considered a Level 3.7 service by ASAM.
- The main focus is to support patients with moderate to severe SUDs to acknowledge, recognize and understand their SUD in order to safely transfer to a less intensive level of care.

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 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 subsequently as needed (a physician assistance, nurse practitioner or psychologist can perform when legally authorized by the state)
- Medication reconciliation initiated within 24 hours

During the ***Rehabilitation Phase of SUD Treatment*** specific medication interventions have been associated with better outcomes and greater retention rates in treatment. These 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.
  - 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 Naltrexone PO (even after one dose.)

- Agonist or mixed agonist/ antagonist maintenance therapies for:
  - Opioids: This should be offered as part of the treatment planning options to opioid use disorder patients who have repeatedly failed to sustain abstinence despite prior completion of rehabilitation treatment.
  - 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.

- renewal as well as continued participation in SUD treatment or recovery community support systems

- 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

OBSERVATION

Introduction

- The observation criteria are used for an individual who has been admitted or is expected to be admitted for psychiatric observation.
- The psychiatric observation is typically for up to 23 hours though may be up to 48 hours in rare situations.
- This level of care is used for acute treatment of specific emergent psychiatric presentations that can be quickly assessed, stabilized and discharged to a less intensive level of care, or to determine the need for a more intensive level of care.
- The psychiatric observation is not the same as a medical observation in that the medical observation is used in general medical settings without specialized psychiatric treatment resources.

Evaluation and Treatment

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

- Blood and urine laboratory screening within 6 hours
- Medical history and physical examination within 6 hours
- Initial psychiatric evaluation within 6 hours and subsequently daily by physician, nurse practitioner or psychologist as legally authorized by the state.
- Nursing assessment within 4 hours and nurse staff observation 24 hours/day
- Multidisciplinary treatment plan within 12 hours

- Psychosocial and substance evaluation within 12 hours
- If deemed necessary, individual or family therapy daily
- Care coordination with other health care or social service providers

RESIDENTIAL TREATMENT CENTER (RTC) – Level 3.5 ASAM

Introduction

- The RTC criteria are used for a patient who has been or is expected to be admitted to a SUD 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, at a minimum, should include:

- Structured therapeutic program at least 4 hours/day
- Preliminary discharge plan initiated within 24 hours
- Medication reconciliation initiated within 24 hours
- Psychosocial and substance use evaluation within 48 hours
- Medication supervision or administration daily

During the ***Rehabilitation Phase of SUD Treatment*** specific medication interventions have been associated with better outcomes and greater retaining rates in the recovery path. These best practices are 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 at high risk for relapse.
  - 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 Naltrexone PO (even after one dose.)

- Agonist or mixed agonist/ antagonist maintenance therapies for:
  - Opioids: This should be offered as part of the treatment planning options for 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.

- The Patient should be reassessed by staff daily to determine ongoing treatment needs and potential impediments to ongoing improvement.
- There should be a Psychiatric assessment within one business day of admission to identify any comorbid conditions.
- Reassessment for mental health conditions should occur no less than weekly thereafter.
- Individual or group family therapy at least 3x/week
- Medical history or physical exam within 6 months prior to or within 30 days after admission
- Nursing staff on-call/on-site 24 hours/day
- On-site supervision 24 hours/day
- Care coordination with other care providers and social services
- Toxicology screen as clinically indicated, quantitative drug analysis, education group, mutual-help as needed

SUPERVISED LIVING – Level 3.1 ASAM

Introduction

- The Supervised Living criteria are used for a patient who has been or is expected to be admitted to a supervised living residence.
- This level of care refers to a licensed residential facility in which paid staff unrelated to the patient provide structured therapeutic group living.
- This level of care is considered a Level 3.1 ASAM.
- Services may be offered within the group home environment.

Evaluation and Treatment

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

- Structured therapeutic program at least 4 hours/day
- Preliminary discharge plan initiated within 24 hours
- Medication reconciliation initiated within 24 hours and medication monitoring
- Psychosocial and substance use evaluation within 48 hours
- Medication supervision or administration daily
- Clinical assessment daily
- There should be a Psychiatric assessment within one week of admission to identify any comorbid conditions.
- Reassessment for mental health conditions should occur no less than monthly thereafter.

- Individual, group or family therapy at least 1x/week
- Medical history or physical exam within 6 months prior to or within 30 days after admission
- Vocational program
- On-site supervision when at residence
- Care coordination with other care providers and social services
- Toxicology screen as clinically indicated, quantitative drug analysis, education group, self-help as needed

PARTIAL HOSPITAL PROGRAM (PHP) – Level 2.5 ASAM

Introduction

- The PHP criteria are used for a patient who is admitted or is expected to be admitted to a PHP and patients admitted to this level of care require ongoing part time clinical support to obtain/maintain abstinence.
- PHP is considered a Level 2.5 ASAM.
- PHP is a time limited, ambulatory treatment program that is offered in the day or evening hours.
- PHP is typically referred to as "day treatment" or acute day hospital and offers at least 20 hours per week of clinically intensive programming within a licensed health care facility.
- PHP goals are to prevent inpatient hospitalization and stabilize functional impairment of a psychiatric or co-occurring moderate to severe substance use disorder.

Evaluation and Treatment

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

- Psychosocial assessment within first program day
- Medication reconciliation initiated within first program day
- Discharge plan initiated upon admission
- The patient should be reassessed on each treatment day to assure that care remains individualized to the patient's needs
- Medication supervision or administration daily

During the ***Rehabilitation Phase of SUD Treatment*** specific medication interventions have been associated with better outcomes and greater retaining rates in the recovery path. These best practices are 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.
  - 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 Naltrexone PO (even after one dose.)

- Agonist or mixed agonist/ antagonist maintenance therapies for:
  - Opioids: This should be offered as part of the treatment planning options for 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.

- Individual, group or family therapy at least 3 hours/day, 5x/week
- Medical or medication evaluation at least 1x/week
- Recover or education group at least 1 hour/day, 5x/week
- Substance use evaluation upon admission and subsequently 1x/weekly
- Psychiatric evaluation and management as needed
- Care coordination with other care providers and social services
- Mutual help group recommended
- Toxicology screen as clinically indicated or breathalyzer as needed

INTENSIVE OUTPATIENT (IOP) – Level 2.1 ASAM

Introduction

- IOP is a time limited, distinct and separate ambulatory program that encompasses a series of sessions appropriate to the patient's individual treatment plan.
- IOP is considered a Level 2.1 ASAM.
- IOP is offered in the day or evening and can be a step down from a more restrictive level of care or a step up to minimize need for a more restrictive level of treatment.
- Program goals are to reduce or prevent the need for IP hospitalization and stabilize symptoms and functional impairment of a psychiatric or co-occurring SU disorder.

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 health care and social service providers
- Individual or group or family therapy at least 2 hours/day, 2x/week

- Programming for 9 or more contact hours/week for adults and 6 or more contact hours/week for adolescents
- Medication reconciliation initiated within first visit

During the ***Rehabilitation Phase of SUD Treatment*** specific medication interventions have been associated with better outcomes and greater retaining rates in the recovery path. These best practices are 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.
  - 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 Naltrexone PO (even after one dose.)

- Agonist or mixed agonist/ antagonist maintenance therapies for:
  - Opioids: This should be offered as part of the treatment planning options for 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 assessment within first visit
- Substance use evaluation within first visit and subsequently 1x/week
- Recovery or education group at least 1 hour/day, 2x/week
- Psychiatric or medication evaluation as needed
- Self-help group recommended
- Toxicology screen as clinically indicated

OUTPATIENT (OP) – Level 1 ASAM

Introduction

- OP criteria are used for a patient who has been admitted or is expected to be admitted to OP psychotherapy or medication management.

- OP services are provided in an ambulatory care setting such as a clinic or office and considered Level 1 ASAM.
- Depending on organizational policy, services may also be provided in other settings such as school, home or via telemedicine.

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 health care and social service providers
- Individual or group or family therapy or medication management less than 2 hours/day twice per week (or less)
- Medication reconciliation initiated within first visit

During the ***Rehabilitation Phase of SUD Treatment*** specific medication interventions have been associated with better outcomes and greater retaining rates in the recovery path. These best practices are 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 recommendations to all alcoholic patients 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.
  - 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 Naltrexone PO (even after one dose).

- Agonist or mixed agonist/ antagonist maintenance therapies for:
    - Opioids - This should be offered as part of the treatment planning option to opioid use disorder patients that have repeatedly failed to sustain abstinence despite prior completion of rehabilitation treatment.
        - Methadone: 40 mg/day – 60 mg/day (sometimes even 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; or,
        - Buprenorphine/naloxone combination (ranging between 4 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 assessment within first visit
- Substance use evaluation within first 2 visits
- Psychiatric or medication evaluation as needed

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

PEER RECOVERY SUPPORT SERVICES

Introduction

- Peer Recovery Support Services and Non-Peer Recovery Support Services are non-clinical services are delivered by a Peer Recovery Coach/Certified Recovery Support Worker (CRSW) to help clients and families identify and work toward strategies and goals for supporting, stabilizing and sustaining recovery.

- May use Z71.9 in the absence of an SUD diagnosis.

- Peer Recovery Coach/CRSW: An individual who has completed a minimum of: 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.

- Peer Recovery coaches/CRSW must be supervised by an MLADC; a LADC that is permitted to independently practice, or a LADC enrolled under a SUD Outpatient or SUD Comprehensive Medicaid provider type, or a LADC who is also a Licensed Clinical Supervisor (LCS); a CRSW who has been approved by the board to provide supervision; 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 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 has 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:
  1. The service is based on a theoretical perspective that has validated research; or
  2. The service is supported by a documented body of knowledge generated from similar or related services that indicate effectiveness.
- 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."

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. 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 (eg, utilizing immunoassay [eg, 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 (eg, utilizing immunoassay [eg, 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 (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, 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

CPT® Codes	Description
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.
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 (eg, 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
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
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
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

HCPCS Codes	Description
	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
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

HCPCS Codes	Description
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
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
F10.10 - F19.99.	Mental and behavioral disorders due to psychoactive substance use.

ICD-10-CM Code	Description
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	Date	Approval Date
New policy.	12/05/18	
Revised background to clarify that immunoassays are able to detect low concentrations of a drug with a high degree of sensitivity but lack some specificity.	03/19	
Revisions and Addition of Peer Support Services	08/30/19	
Revised policy to state that HCPCS codes G0482 & G0483 are not medically necessary, and to reflect a 10 day post-collection authorization period. Updated coding tables to include 80367, 80368, 80369, 80370, 80372, and 80373. Revised I.A.1 from "unless no reliable test is available" to "unless no reliable test is in existence" for clarification.	05/19	05/19
References reviewed and updated.	06/19	
Added Appendix A copied from CP.MP.50, Outpatient Testing for Drugs of Abuse	11/19	11/19
Revised description to include Medicare, revised policy / criteria section by moving the policy and criteria section to the correct formatting on the template, added criteria content to reflect age, diagnosis, and appendix reference, moved ASAM LOC criteria after the background section, added content to the background section to update the definition of a substance use disorder, amended "role of medication-assisted treatment (MAT) and removed "detox" and added "maintenance", updated Categories of Medication section to clarify used to support abstinence and recovery, updated medications used to treat overdose and withdrawal states, changed "detox" to "withdrawal", included administration of B1 (Thiamine), revised Medications Used to Maintain Abstinence section – added Acamprosate medication protocol under Naltrexone section, changed "alcoholic patients" to "treating alcohol use disorder", updated content to reflect current clinical	11/19	11/19

Reviews, Revisions, and Approvals	Date	Approval Date
terminology, updated dosing and route of administration under Naltrexone, updated Opioids section – changed opiates to opioids, updated administration protocol under Methadone, updated administration protocol under Buprenorphine, under alcohol section – updated Disulfiram administrative protocol, under Additional MAT Considerations – added content to reflect participants in treatment planning, under MAT in Specific Populations – expanded content to reflect treatment standards regarding adolescents and woman who become pregnant, under Level of Care Guidelines – moved section to the correct formatted section in the template, added sentence to clarify application of ASAM guidelines, changed detoxification to withdrawal, removed Appendix A – Daily Testing Section and Appendix B – Toxicology Screening Guidelines.		
Added Opioid Educational Tools Repository to References	1/20	2/20
Revised HCPSC Code description for G0396 and G0397	9/20	
Annual Review. References reviewed and updated. Removed duplicate references. Removed "American Society of Addiction Medicine. Public Policy Statement on Drug Testing as a Component of Addiction Treatment and Monitoring Programs and in Other Clinical Settings. Revised October 2010 Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43.)," as the policy statement is archived and no longer considered active ASAM policy. Added updated statistics to Background Section. Removed reference Wilfong A. Seizures and epilepsy in children: Initial treatment and monitoring. In: UpToDate, Nordli DR (Ed), UpToDate, Waltham, MA. Accessed 11/5/2020 as it does not applicable to policy content. Update. Changes in formatting were made to pages 6-23.	11/20	11/20

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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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to

recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.