

Regence Behavioral Health Policy and Procedure

Title: Substance Related Disorders, Treatment of Child and Adolescents

Lines of Business: All

Functional Area: All Health Care Services

Date of Origin: January 1996

Revised/Approved Date: December 1, 2009

Effective Date: December 1, 2009

Purpose:

IMPORTANT REMINDER

The purpose of this Regence policy and procedure is to provide a guide to coverage. Regence policy is not intended to dictate to providers how to practice behavioral health treatment. Providers are expected to exercise their medical judgment in providing the most appropriate care.

Behavioral Health Policy and Procedures are developed through consideration of medical necessity, generally accepted standards of medical practice, published professional association clinical guidelines and the review of medical literature. Regence supports the use of practice guidelines to assist in determinations of the clinical appropriateness of treatment services provided for mental health and chemical dependency disorders. The practice guidelines describe generally accepted practices and were developed by nationally recognized organizations. These guidelines are available to providers and members by calling **1 (800)780-7881** or on our external web site at: <http://www.wa.regence.com/provider/library/manual/core/2009/washington-behavioral-health-mental-health-chemical-dependency.pdf>. Regence is committed to comply with all applicable Federal and State regulations.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

Definition:

- This Behavioral Health Policy includes the terms: Substance Related Disorders, Substance Disorders, Substance Abuse, Substance Dependence, Chemical Dependency, and Substance Induced Disorders as consistent with the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition-Text Revision and the American Society of Addiction Medicine Patient

Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised.

- The term ‘Substance’ can refer to a drug of abuse, a medication, or a toxin.
- Substance Dependence is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. The essential feature of substance dependence is a cluster of cognitive, behavioral and physiological symptoms which indicate that the individual continues use of the substance despite significant substance related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal and compulsive drug-taking behavior. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems. These problems must occur recurrently during the same 12-month period.
- Unlike substance dependence, substance abuse criteria do not include tolerance, withdrawal or a pattern of compulsive use. Instead, the criteria include only the harmful consequences of repeated use (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM-IV™).

Policy:

Coverage for the stabilization of substance related disorders for adults will be approved subject to the following policy.

Treatment Principles

- Facilities providing treatment for Substance Related Disorders are required to provide comprehensive biopsychosocial assessments and individualized treatment plans, including formulation of problem statements, treatment goals, and measurable objectives – all developed in consultation with the patient.
- It is understood that family therapy as a component of chemical dependency treatment is an integral aspect of the comprehensive individualized treatment plan if the member has family and significant partnerships.
- Treatment programs typically have active affiliations with other levels of care, and staff can help patients access support services. If patients worsen or fail to improve in a given level of care or with a given type of program within a level of care or service, changing the level of care or changing the program should be based upon a reassessment of the treatment plan with modifications to achieve a better therapeutic response. Failure of a patient to progress at a given level of care may require transfer to a specialized program at the same, more intensive, or less intensive level of care to achieve a better therapeutic response.
- Given the high comorbidity of substance abuse disorders with other DSM-IV Axis I disorders, especially anxiety and depression, accessibility to psychiatric consultation and follow-up care, when indicated, should be made available.

Distinct Treatment Levels of Care

- Specific levels of care are available for the treatment of Substance Related Disorders. Progress through the levels of service is dependent on continual assessment of certain problems and priorities that are identified as justifying admission to a particular level of care. The resolution of those problems and priorities determines when a patient can be treated at a different level of care or discharged from treatment. The appearance of new problems may require services that can be effectively provided at the same level of care, or that require a more or less intensive level of care.
- The determination of whether a member meets the medical necessity criteria for discharge and transfer to any alternate level of care is a medical necessity determination for benefit coverage based on clinical information obtained.
- The facility and provider must be licensed to provide the level of care by the State in which they operate.

Acute Inpatient Detoxification

Acute inpatient detoxification services encompass the assessment and medical stabilization of severe medical withdrawal symptoms, or monitoring of significant risk of severe medical withdrawal symptoms. Programs provide a planned regimen of 24 hour medically directed evaluation, care and treatment for a primary diagnosis of Substance Related Disorders in an acute care inpatient detoxification setting. The service is staffed and provided by designated addiction credentialed physicians, often including psychiatrists, as well as other mental health and addiction credentialed clinicians, all of whom have expertise in working with adults. Such services are in permanent facilities that include detoxification inpatient beds. These facilities provide care to patients whose mental and substance related problems are so severe that they require primary biomedical, psychiatric and nursing care. The full resources of a general acute care hospital or psychiatric hospital should be available. The intensity of detoxification services are based on withdrawal history and the amount, frequency, chronicity and recency of discontinuation of, or significant reduction in, alcohol or other drug use. Comprehensive biopsychosocial assessment and linkage to non-detoxification services are necessary to facilitate the patient's completion of detoxification and timely entry into the least restrictive and safe level of care for the continued medical, addiction, or mental health treatment and self-help recovery. Immediate and continued treatment is necessary to avoid repeated cycles of recovery, relapse, and readmission.

Inpatient Treatment

Medically monitored (intensive inpatient) and clinically managed (high intensity inpatient) treatment, for the stabilization of sub-acute withdrawal symptoms and addictive patterns that prevent progress in a less intensive level of care, provide a planned regimen of 24 hour care and treatment for a primary diagnosis of a Substance Related Disorder(s) where the patient can reside safely. The patient may be at risk of withdrawal, but symptoms are manageable and do not require full medically managed detoxification resources. Inpatient treatment is staffed by designated addiction-credentialed physicians, often including psychiatrists, as well as other mental health and addiction-credentialed clinicians. Such services are housed in permanent facilities and provide care to patients whose mental and substance-related problems are so severe that they require biomedical,

psychiatric and nursing care monitoring and intensive clinical management. Mutual and self-help group meetings are available on site. Comprehensive biopsychosocial assessment and linkage to lower level of services are necessary to facilitate the patient's stabilization and timely entry into continued medical, addiction, or mental health treatment and self-help recovery as indicated to avoid revolving treatment admissions and repeated cycles of recovery and relapse.

Residential Treatment

Residential treatment encompasses organized clinical management (medium and low intensity) services staffed by designated addiction treatment (and often mental health personnel) who provide a planned regimen of care in a 24 hour permanent facility where patients can reside safely. Mutual and self-help group meetings are available on-site. The defining characteristic of residential treatment is the provision of safe and stable living environments in order to develop the minimal necessary recovery skills to establish and maintain abstinence in an outpatient setting. Residential treatment is for patients with minimal problems with intoxication or withdrawal and few biomedical complications, so onsite physician services are not required in a 24 hour setting. Such individuals may have relatively stable problems in Axis I and/or less stable problems in Axis II of the Diagnostic and Statistical Manual of Mental Disorders. Many also have significant deficits in the readiness to change, relapse, continued use or continued problem potential or recovery environment.

“Rehab” or “rehabilitation” is synonymous to residential treatment in various regulations for the treatment of a substance related disorder(s), although the definition is not applied uniformly. This Regence policy and procedure uses the standard definition of “rehabilitation” as *the process or general treatment for a substance related disorder in ANY level of care*

Partial Hospitalization Program (PHP)/Day Treatment

Partial hospitalization program/day treatment for substance related disorders involves highly organized services but does not involve an overnight stay by the patient. The patient warrants daily monitoring or management, but problems can be appropriately addressed in a structured partial hospital program/day treatment. The program must provide at least 20 hours per week of treatment, although less than 20 hours per week of care may be received by the patient when specific criteria are met. The partial hospital program provides direct access to or close referral relationships with psychiatry, access to medical and laboratory services, and is staffed by appropriate trained and credentialed addiction treatment staff. The partial hospital program/day treatment has an available psychiatrist for evaluation and medication assessment within 48 hours of request as needed. Such patients also need case management services to facilitate their reintegration into the larger community.

Outpatient Treatment

Outpatient treatment is provided to patients who require services of a less intensive schedule than would be provided in a partial hospitalization program/day treatment, for

example, one hour of treatment per week, or, two to three hours of treatment provided three to four times per week defined as **Intensive Outpatient Treatment (IOP)** for the treatment of substance related disorders. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within “real world” environments. IOP programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24 hour crisis services.

Treatment Planning in All Levels of Care

All substance disorder treatment levels provide comprehensive biopsychosocial assessments and individualized treatment plans, including formulation of problem statements, treatment goals, and measurable objectives – all developed in consultation with the patient. Such programs typically have active affiliations with other levels of care, and staff can help patient’s access support services. If patients worsen or fail to improve in a given level of care or with a given type of program within a level of care or service, changing the level of care or changing the program should be based upon a reassessment of the treatment plan with modifications to achieve a better therapeutic response. Failure of a patient to progress at a given level of care may require transfer to a specialized program at the same, more intensive, or less intensive level of care to achieve a better therapeutic response.

Medical Necessity Criteria

The following criteria for each of the following levels of care must be met in order for the treatment to be considered medically necessary for admission, continued stay, discharge or transfer to another level of care for the treatment of a substance related disorder:

Acute Inpatient Detoxification

Admission to an acute inpatient detoxification setting for the treatment of substance dependence may be considered medically necessary when the following criteria are met:

1. The presence of withdrawal symptoms, medical risk of withdrawal, or imminent risk of withdrawal compromises a medical condition:
 - a. A substance-induced medical disorder, such as alcoholic hepatitis or acute pancreatitis, is likely to progress in severity with continued alcohol or drug use.
 - b. Alcoholic myopathy, with or without myoglobinuria.
 - c. Serious disulfiram-alcohol rejection with hypothermia, chest pains, arrhythmia or hypertension.
 - d. Medical management is needed in order to avoid complications due to withdrawal.
 - e. A history or evidence of recent convulsions or a poorly controlled convulsive disorder.
 - f. Signs of impending or active withdrawal, such as autonomic syndrome of fever, tachycardia, hypertension, dilated pupils, sweating, extreme agitation, disorientation, or hallucination which become more severe after

cessation of alcohol or drug use, and these constitute a medical emergency.

- g. Fluctuations in level of consciousness which are prolonged or unexplained, including comatose or stuporous conditions.
- h. Depression with expressed hopelessness or suicidal ideation.
- i. An infectious disease which is likely to become aggravated due to co-existing use of alcohol or drugs.
- j. A systemic disease or known of unknown cause with a fever of 101 degrees F or above, or hypothermia at or below 95 degrees F.
- k. A metabolic problem needing 24-hour medical supervision, such as diabetes mellitus, hypoglycemia 45 mg/dl, or acidosis with or without ketosis.
- l. Congestive heart failure or significant hypertension, tachycardia, or arrhythmia.
- m. Active gastrointestinal bleeding, significant vomiting, or dehydration.
- n. Significant degree of anemia.
- o. A medical condition such as paraplegia which, in combination with the chemical dependency, requires 24-hour RN supervision.
- p. Patient is unable to be satisfactorily managed in an outpatient, residential or partial hospitalization setting as documented by unsuccessful trials in such settings.

Documented Service Requirements in an Acute Detoxification Setting

In addition to the above, the provider must document that the patient is receiving (or will receive) the following:

1. Psychosocial evaluation and substance abuse evaluation and within the first 48 hours.
2. Initial full medical evaluation by a physician, including a comprehensive history, physical examination, and mental status examination.
3. Physician visits daily (7 days per week), with medical management of withdrawal symptoms.
4. 24 hour nursing care.
5. Drug/urine screen upon admission.
6. Laboratory studies such as liver function studies, blood chemistry profile, and serum enzymes, etc.
7. Formulation of a multidisciplinary comprehensive treatment plan containing specific problem formulation, goals, planned interventions and time to achieve these, pharmacotherapy or other medical care.
8. Discharge planning for lower level of care is initiated within admission and includes provision for ongoing chemical dependency treatment after discharge.
9. With the member's permission, contact with clinicians involved in the member's treatment prior to admission to obtain all relevant information and input within 48 hours of admission and again just prior to discharge for the communication of the discharge summary and plan.

Justification for Continued Acute Detoxification Inpatient Stay:

Continued Inpatient Stay may be considered medically necessary if there is documentation of one or more of the following criteria:

1. Continued delirium tremens, other withdrawal symptoms, or injury while disoriented that require 24-hour medical management.
2. Complications of medication(s).
3. Progressive hepatic or gastrointestinal bleeding.
4. Aspiration pneumonia.
5. Attempted suicide or high suicidal risk.
6. Development or persistence of temporary alcoholic psychosis (patients with other forms of psychosis should be transferred to an appropriate dual diagnosis program).
7. Medical treatment goals are not met, but significant progress is documented.

Indications for Discharge or Transfer to a Less Intensive Treatment Setting:

Indications for discharge from an acute inpatient detoxification setting and transfer to a less intensive level of care for the treatment of substance dependence may be considered medically necessary when the following criteria are met:

1. Medical, surgical and psychiatric stability.
2. All sedative medications used for withdrawal are discontinued, and the patient is able to sleep for four hours continuously without sedation.
3. Post hospital rehabilitation plans are completed, and a specific follow-up treatment plan is established.
4. Medical treatment goals are achieved.

Inpatient Treatment

Admission to an inpatient treatment setting for the treatment of substance dependence may be considered medically necessary when the following criteria are met:

1. The patient has a primary active DSM-IV™ psychoactive substance dependency disorder diagnosis (excluding caffeine or nicotine abuse or dependence), and at least one indicator from criterion 2 or 3 below is met; at least one indicator from criterion 4 or 5 below is met; and criterion 6 below is met.
2. There is a pattern of substance dependence as evidenced by:
 - a. Current multiple alcohol or drug related problems, e.g., trauma, gastrointestinal or liver disease, etc.
 - b. The severity and intensity of the substance dependence (chemicals used, poly-drug abuse, frequency and intensity of use) is coupled with a demonstrated inability to attain and/or maintain abstinence.
3. Behavioral/psychological/personal cluster - the factors listed below must be related to substance dependence and its consequences but can be safely managed in a 24 hour medical monitoring setting, and does not need the full primary resources of a licensed psychiatric hospital:
 - a. Current suicidal ideation without a specific plan or intent to harm self.
 - b. Concurrent emotional/behavioral crisis needing stabilization.
 - c. Significant potential for assaultive behavior.

- d. Affective symptoms with disruption of activities of daily living.
 - e. Thought process impairment.
 - f. Significant risk of failure to maintain sobriety without 24-hour supervised treatment. The need for 24 hour supervision is demonstrated when the patient does not accept or relate to the severity of his or her problems, despite serious consequences or effects of the addiction on the patient's life (health, family, work or social).
4. Environmental support system cluster - the environment in which the patient lives, when coupled with other relevant clinical indicators, impacts the treatment process and reduces the likelihood of success in a less intensive treatment:
 - a. The patient is experiencing severe isolation or withdrawal from social contacts, and there is evidence that outpatient treatment alone will not break this pattern.
 - b. The patient lives in an environment in which treatment is unlikely to succeed; e.g., a chaotic family, in which interpersonal conflict is prevalent, and which undermines the patient's efforts to change; or an environment in which there is an immediate danger of physical or sexual attack.
 - c. The patient is engaged in an occupation where continued alcohol and/or drug use on the part of the patient constitutes substantial imminent risk to the self or others.
 5. Other factors:
 - a. History of failure(s) in other levels of care despite motivation.
 - b. Court or employer mandate for residential treatment if relevant clinical factors justify admission.
 - c. Significant travel or geographical barriers to other treatment modalities.
 6. The patient is at risk of withdrawal or has a co-occurring medical condition, but can be safely managed in a 24 hour medical monitoring setting, and does not need the full resources of a licensed hospital.

Documented Service Requirements of Inpatient Treatment:

1. Initial full medical evaluation by an interdisciplinary staff of appropriately credentialed treatment professionals, including addiction-credentialed physicians. Treatment is specific to substance-related disorders, but the skills of the interdisciplinary team and the availability of support services can accommodate sub-acute detoxification and/or intensive inpatient treatment of addiction and or conjoint treatment of co-occurring sub-acute biomedical and or emotional, behavioral or cognitive conditions.
2. A psychiatrist is available for evaluation and medication assessment within 48 hours of request as needed. Unless contraindicated, psychotropic medication is prescribed by the attending psychiatrist or physician for those conditions known to be potentially responsive to psychopharmacological intervention and if it is clinically indicated. Member/family resistance to medication for such conditions is made a focus of treatment.
3. Drug/urine screen upon admission.
4. Laboratory studies such as liver function studies, blood chemistry profile, and serum enzymes, etc.

5. Formulation of a multidisciplinary comprehensive treatment plan containing problems, specific treatment goals, planned interventions to achieve these, and anticipated time frame and therapeutic modalities such as individual, group, and family therapy, and medical monitoring.
6. Discharge planning is initiated on the day of admission.
 - a. The severity and intensity of the substance dependence (chemicals used, poly-drug abuse, frequency and intensity of use) is coupled with a demonstrated inability to attain and/or maintain abstinence.
7. Monitoring for behavioral/psychological/personal factors listed below must be related to substance dependence and its consequences.
 - a. Current suicidal ideation without a specific plan or intent to harm self.
 - b. Concurrent emotional/behavioral crisis requiring monitoring.
 - c. Significant potential for assaultive behavior.
 - d. Affective symptoms with disruption of activities of daily living.
 - e. Some degree of thought process impairment, although the patient can be safe and able to respond to and benefit from treatment in a medical monitoring and clinically managed setting.
8. Significant risk of failure to maintain sobriety without 24-hour supervised treatment. The need for 24-hour supervision is demonstrated when the patient does not accept or relate to the severity of his or her problems, despite serious consequences or effects of the addiction on the patient's life (health, family, work or social).
9. Additional criteria:
 - a. History of failure(s) in other levels of care despite motivation.
 - b. Court or employer mandate for residential treatment if relevant clinical factors justify admission.
 - c. Significant travel or geographical barriers to treatment at a lower level of care.

Justification for Continued Inpatient Treatment Stay:

Justification for continued inpatient treatment stay may be considered medically necessary when the patient is actively engaged and making progress in treatment goals and any two of the following are met:

1. The patient continues to be at risk of withdrawal, but requires and is safely manageable with 24 hour medical monitoring, and does not need the full resources of a licensed medical or psychiatric hospital.
2. The patient's co-occurring medical condition continues to require and be managed in a 24 hour medical monitoring setting.
3. The patient's co-occurring psychiatric condition continues to require and is manageable in a 24 hour medical monitoring and clinical management setting.
4. The patient is unable to control substance use, with imminently dangerous consequences, despite active participation at less intensive levels of care.

Indications for Discharge and Transfer to a Less Intensive Treatment Setting from Inpatient Treatment:

1. Medical, surgical and psychiatric stability.

2. A specific follow-up treatment plan is established.
3. Medical treatment goals are achieved.
4. The patient can be safely treated in an alternative treatment setting or is not amenable to treatment despite appropriate treatment interventions.

Residential Treatment

Admission to a residential may be considered medically necessary when the criteria in both 1 and 2, below, and either 3, 4, 5a, 5b, or 5c are met:

1. The patient has a primary active DSM-IV™ psychoactive substance dependency disorder diagnosis (excluding caffeine or nicotine abuse or dependence), exhibits a pattern of pathological substance use and is unable to discontinue alcohol and/or drug use without a 24 hour structured program. The severity and intensity of the substance dependence is coupled with a demonstrated inability to attain and/or maintain abstinence as evidenced by at least three of the following:
 - a. Withdrawal symptoms requiring daily medical monitoring or management although does not require 24 hour monitoring and/or management.
 - b. Daily or regular use of alcohol and/or drugs.
 - c. Inability to cut down or stop alcohol and/or drug use in spite of negative consequences and/or promises.
 - d. Personality changes such as hostility, inhibition, social withdrawal, isolation, or violence.
 - e. Inappropriate use of alcohol and/or drugs related to time, place, amount or intent.
 - f. Amnesic or blackout periods while under the influence of alcohol and/or drugs.
 - g. Poly-drug use.
 - h. Severe progression of the substance related disorder.
 - i. Relief use of substances.
 - j. Change in tolerance to alcohol and/or drugs.
 - k. Recent history of overdose, severe intoxication, periods of unconsciousness, or hallucinations.
2. The patient exhibits impairment in social functioning due to alcohol and/or drug use, as evidenced by the occurrence of at least two of the following types of episodes within the past 12 months:
 - a. Problems with employment such as declining performance. If unemployed, the patient lacks a daily structure.
 - b. Conflict with peers, change of peer group, or social isolation that is related to the use of substances.
 - c. Relationship conflict. The patient may have continued acute problems despite family/couples therapy.
 - d. Legal problems resulting from the patient's substance use.
 - e. Changes in the patient's social activities that are considered high risk.
3. The environment and support system impacts the treatment process and reduces the likelihood of success of less intensive treatment level of care. The patient must have at least one of the following:

- a. The patient resides in an environment where someone is actively abusing or dependent on substances or is living in a dysfunctional family home environment.
 - b. The peer group is primarily substance users and the patient lacks peer avoidance and refusal skills (or the patient has no peer group identification). This poses a high risk to successful recovery in a less intensive level of care.
 - c. The patient lacks adequate structure and support at home and is likely to cause a barrier to treatment success in an outpatient setting, and an alternative supportive setting is not available.
4. The patient's behavioral or psychiatric risk factors must exhibit at least one of the following:
- a. Strongly "established denial system".
 - b. Vague suicidal ideation related to substance use and its consequences
 - c. History of assaultive behavior
 - d. Increased signs of significant mood swings and personality changes which are disruptive to the patient's ability to participate and benefit from outpatient treatment.
5. Other factors:
- a. Previous failure(s) in outpatient treatment or other substance dependence focused professional intervention.
 - b. Family or significant other agreement that treatment is necessary and there is willing to participate.
 - c. There are geographical or access barriers to outpatient treatment.
 - d. If the patient has a medical condition or is at risk of moderate to minor sub-acute withdrawal symptoms, they can be safely treated in an inpatient level of care for the treatment of a primary substance abuse disorder.

Documented Service Requirements Residential Treatment

In addition to the above, the provider must document that the patient is receiving (or will receive) the following:

- 1. Initial comprehensive history, physical examination and mental status examination within 48 hours of admission, unless the patient is stepping down from another level of care where these were performed.
- 2. Medical problems evaluated and treated by a physician in a timely manner.
- 3. An individualized treatment plan which includes a problem formulation, treatment goals and recommended therapeutic modalities such as individual or group therapy, pharmacotherapy or other medical care.
- 4. Availability of a psychiatrist for evaluation and treatment as needed in a timely manner.
- 5. The patient must be staying overnight at the facility and must be involved in a structured treatment program intensity comprised of at least eight (8) hours per day, five (5) days.
- 6. All therapeutic services must be provided by state licensed or certified chemical dependency professionals.

Justification for Continued Stay in Residential Treatment

Documentation must substantiate continued progress towards clear and measurable treatment goals that are only attainable in a non-outpatient treatment setting. In addition, documentation of one or more of the following conditions should exist to be considered medically necessary for continued stay in a residential treatment:

1. Documented treatment goals are not met but significant progress is occurring, and care is not primarily maintenance or custodial.
2. The patient's behavioral, medical or psychological status continues to require a 24 hour/day structured treatment setting, and this is specifically documented in the patient's chart.
3. There is documentation of new clinical problems whose resolution is determined to be essential to the successful completion of the treatment program, and which require treatment in a 24 hour/day structured treatment setting.

Indications for Discharge from Residential Treatment

1. Documented treatment goals are achieved, or the patient is sufficiently advanced in meeting treatment goals that step down to a less intensive setting may be safely accomplished .
2. The disorder or condition has been evaluated, and it has been determined that the patient cannot be appropriately treated in a residential treatment setting because:
 - a. Treatment can be completed in a less restrictive setting as evaluated by the treatment provider based on the previously defined criteria, or
 - b. Behavioral, psychological or medical problems necessitate transfer to an alternative setting.
3. There is a continued refusal of the patient to cooperate in treatment or comply with the treatment plan, or a lack of measurable progress towards treatment goals; e.g., the patient has failed to reach Step 1 in a 12-step program; or the patient has not begun to acknowledge the existence of or need for amelioration of the substance dependence problem.

Partial Hospital Program (PHP)

Patients stepping down from inpatient or residential substance abuse treatment typically step down to intensive outpatient treatment. A partial hospital program may be medically necessary for those individuals requiring a more intensive program. Admission to a Partial Hospital Program may be considered medically necessary for patients who meets the diagnostic criteria for a DSM Axis I or ICD-9 Substance Abuse and/or Dependence diagnosis, and who do not require treatment in an inpatient or residential setting.

1. The member is not medically at risk, or any medical complications can be appropriately managed on an outpatient basis.
2. The patient is at low risk of harm to self or others and is safely manageable in a partial hospital program, as are symptoms of any diagnosed psychiatric comorbidity.

3. Symptoms or behaviors are present which could lead to a deterioration in functioning and the need for a inpatient or residential treatment, if not addressed at the intensity of service provided in a PHP.
4. The patient's recovery environment may impede recovery, although can be closely monitored and treated safely in partial hospital program providing the required intensity of service, with anticipated response over time.
5. The patient's family or significant relationships are supportive and committed to treatment.
6. The patient may not recognize the extent and severity of problems caused by the substance abuse disorder and/or may not accept the diagnosis, however can be safely treated in a partial hospital program.
7. The patient may have a relapse potential, however it can be safely addressed and treated in a partial hospitalization program.

Documented Service Requirements for Partial Hospital Program

1. All services are provided by state-licensed or state-certified professionals.
2. Therapeutic programming is provided a minimum of six hours per day, 5 days per week.
3. Comprehensive psychosocial evaluation and chemical dependency evaluation is performed within the first 24 hours after admission.
4. Discharge planning is initiated on the day of admission.
5. Psychiatric evaluation and other medical evaluation is available and provided in a timely manner, if indicated.
6. The patient is being treated under an individualized problem focused treatment plan, including family therapy when indicated.
7. Provision for random drug screens and treatment plan modifications to address substance use while in treatment.
8. Coordination of care with other clinicians in the community who are currently providing services to the patient, or who will upon discharge.

Intensive Outpatient Program (IOP)

IOP may be considered medically necessary for all patients who have an active DSM-IV™ psychoactive substance related disorder and who, based on the criteria for the above treatment settings, do not require treatment in the inpatient, residential, or partial hospitalization program settings.

1. The patient is not medically at risk.
2. The patient is at low risk of harm to self or others and is manageable in an intensive outpatient program
3. The patient's recovery environment may impede recovery, although can be closely monitored and treated safely in an intensive outpatient program with anticipated response over time.
4. The patient's family or significant relationships are supportive and committed to treatment.
5. The patient may not recognize the extent and severity of problems caused by the substance abuse disorder and/or may not accept the diagnosis, however can be safely treated in an intensive outpatient program.

6. The patient may have a relapse potential, however it can be safely addressed and treated in an intensive outpatient program.

Documented Service Requirements for Intensive Outpatient Program

1. Services occur at least 3 hours per day, 3 times per week, decreasing as clinically indicated. All services are provided by state-licensed or state-certified professionals.
2. The member receives a comprehensive chemical dependency evaluation prior to or at the outset of CD IOP treatment, including assessment of or referral for assessment of any co-occurring mental health conditions.
3. The member is treated according to an individualized, problem-focused treatment plan, including family involvement when indicated.
4. Discharge planning is initiated on the day of admission.
5. The program can facilitate timely access to psychiatric evaluation and treatment, as needed.
6. Provision for random drug screens and treatment plan modifications to address substance use while in treatment.

Justification for Continued Treatment in the IOP

Documentation of one or more of the following conditions for continued stay in an intensive outpatient setting:

1. Documented treatment goals are not met but significant progress is noted.
2. A less intensive outpatient program has been attempted but did not result in the patient achieving or maintaining abstinence.
3. There is documentation of new clinical problems whose resolution is determined to be essential to the successful completion of the treatment program (e.g., has not developed a relapse prevention plan).
4. There are documented treatment failures which necessitate changes in the treatment plan, indicating the need for continued outpatient therapy.

Indications for Discharge

1. Documented treatment goals are achieved.
2. The disorder or condition has been evaluated, and it has been determined that the outpatient treatment setting is no longer appropriate because:
 - a. The patient is unable to maintain abstinence and is not making significant progress towards the treatment goals; and
 - b. Treatment must be continued in a more restrictive setting; e.g., residential or inpatient.
 - c. The patient has demonstrated an inability to meet attendance requirements.

Outpatient Treatment

Outpatient substance abuse/dependence treatment may be considered medically necessary for all patients who have an active DSM-IV™ psychoactive substance related disorder and who, based on criteria for the above settings, do not require treatment in the inpatient, residential, partial hospital or intensive outpatient treatment setting. Typically outpatient treatment is delivered at a frequency of one to two times per week for several weeks following completion of an intensive outpatient program, and may then be tapered to a frequency of less than once weekly if continued therapeutic support is needed for a period of time. For some patients, this level of care may be the initial treatment modality for the Axis I substance abuse/dependence condition.

1. The patient is not medically at risk
2. The patient is at very low risk of harm to self or others and is manageable in an outpatient setting.
3. A comprehensive drug and alcohol assessment is documented at the outset of outpatient treatment, including assessment of family and social support.
4. The patient's recovery environment is supportive of the patient's recovery.
5. The patient is treated under an individual treatment plan, focused on formulation of recovery goals and relapse prevention strategies, with adjunctive use of community-based programs.
6. Referral is made for concurrent psychiatric evaluation and treatment for patients with a known or suspected comorbid DSM-IV Axis I diagnosis.
7. Drug screens are obtained in a timely manner if indicated.

Not Medically Necessary

The following conditions are not considered Medically Necessary and are excluded from authorization of coverage for Substance Related Disorders: Treatment of Adults.

1. Conditions or disorders which are excluded from authorization of coverage under the specifications of the health plan.
2. Treatment which is court ordered solely as an alternative to management within the justice system or required by a third party.
3. Treatment as a substitute for other social/community resources.
4. Treatment for the purpose of providing custodial care, respite for the family, or purely antisocial behavior.
5. Treatment for the sole purpose of removing the adult from home/community who is unlikely to respond to treatment.
6. Treatment for the sole purpose of separating and protecting an adult from a dysfunctional, unstable, noxious, or abusive environment.
7. Settings which are primarily residential sober housing.

Procedure:

Regence Behavioral Health Medical Management Coordinators (MMC)

- Utilization management is conducted by behavioral health care professionals who have valid and current licensure.
- Regence policy specify the type of personnel responsible for each level of UM decision-making. The Behavioral Health Medical Director will approve all denials of behavioral health treatment payment passed on medical necessity. The

behavioral health clinical care coordinator will refer BH cases to the medical director according to the Behavioral Health Procedure, “Guidelines for Referral to a Medical Director”.

- A training plan on policies, procedures, and guidelines is in place for MMCs who conduct utilization management.
- There is a supervisory procedure in place for the evaluation of adherence with policy and procedures, including inter-rater reliability for utilization management decisions.
- Regence does not provide MMC incentives to deny services.
- Providers and enrollees can obtain the UM decision-making, timeline and appeal criteria upon request by calling 1-(866)543-5765 or by viewing policy and procedures on the Regence web site at www.regence.com.

References:

- This procedure has been developed with consideration of medical necessity, generally accepted standards of medical practice, review of medical literature, and applicable state or national regulations as required.
- Informed by Milliman Care Guidelines as applicable.
- ASAM PPC-2R ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised.
- American Psychiatric Association Clinical Practice Guidelines (www.apa.org).

Cross References:

- This procedure has been developed with consideration of medical necessity, generally accepted standards of medical practice, widely accepted clinical guidelines published by professional associations, and review of medical literature.
- Informed by Milliman Care Guidelines as applicable.
- American Psychiatric Association Guidelines for Adults (www.apa.org).
- Regence Behavioral Health Facility Admissions