BlueCross BlueShield of North Carolina

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Corporate Medical Policy

Substance Use Disorder Intensive Outpatient Programs "NOTIFICATION"

File Name: substance_use_disorder_intensive_outpatient_programs
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Policy Effective 7/1/2024

Description of Procedure or Service- Substance Use Disorder Intensive Outpatient Programs

Substance Use Disorder Intensive Outpatient Programs (IOP) provide time-limited, multidisciplinary, multimodal structured treatment for chemical dependency in an outpatient setting. IOP is intended to provide treatment on an outpatient basis, does not include boarding/housing and is intended to provide treatment interventions in a structured setting, with patients returning to their home environments or a community-based setting each day. IOP does not include treatment in a locked unit or restricted access setting.

Related Policies:
Substance Use Disorder Intensive Outpatient Programs
Treatment For Opioid Use Disorder in Opioid Treatment Programs (OTPs)

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will provide coverage for Intensive Outpatient Programs (IOP) for Substance Use Disorder when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this medical policy.

Coverage for services described in this medial policy may be subject to prior authorization by Blue Cross Blue Shield of North Carolina or its designee.

When Substance Use Disorder Intensive Outpatient Programs (IOP) is covered

Treatment for Substance Use Disorder Intensive Outpatient Programs may be considered medically necessary when members meet ALL the criteria listed below**.**

1. If required by state statute, the facility is licensed by the appropriate state agency that approves healthcare facility licensure.

2. There is documentation of drug screens and relevant lab tests upon admission and as clinically indicated.

3. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within 3 days of admission and amended as needed for changes in the individual's clinical condition. Elements of this plan include, but are not limited to subjects such as identification of key precipitants to current episode of treatment, assessment of psychosocial supports available after discharge, availability of aftercare services in member's home geographic area, potential need for supportive living placement to continue recovery, consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan, need for services for comorbid medical or psychiatric conditions, contact with aftercare providers to facilitate an effective transition to lower levels of care and other issues that affect the likelihood of successful community tenure.

4. Treatment programing includes documentation of at least one individual counseling session weekly or more as clinically indicated.

5. The member and/or family member should be made aware of FDA approved Medications for Addiction Treatment (MAT) available. The facility should document informed consent including the risks and benefits of MAT treatment as well as the risks of no MAT treatment. MAT is defined as the provision of medications during rehabilitation, not only withdrawal management strategies.

6. A licensed behavioral health practitioner documentation says the member is evaluated on each program day.

7. Mental health and medical services are available 24 hours per day, seven days per week either on-site or off-site by referral.

8. A multidisciplinary treatment program occurs a minimum of 3 days per week and provides a minimum of 9 hours of weekly clinical services to comprehensively address the needs identified in the member's treatment plan. If the treatment program offers activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting symptoms, Blue Cross NC does not count these activities in the total hours of treatment delivered.

9. When members are receiving boarding services, during non-program hours the member is allowed the opportunity to:
    a. Function independently.
    b. Develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.

10. There is documentation of a safety plan including access for the member and/or family/support system to professional support outside of program hours.

11. Family participation:
    a. For adults: Family treatment is being provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.

    b. For children/adolescents: Family treatment will be provided as part of the treatment plan. If Family treatment is not held, the facility/provider specifically lists the contraindications to Family Therapy unless clinically contraindicated. The family/support system assessment will be completed within 72 hours of admission with the expectation that family is involved

in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly.

c. Family participation may be conducted via telephonic or virtual sessions when there is a significant geographic or other limitation.

12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within five days of admission.

Admission Criteria:
Must meet 1- 8 and at least one of 9, 10 or 11:

1. A DSM diagnosis of substance use disorder, which is the primary focus of active treatment each program day.

2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure, and support.

3. The treatment is not primarily social, interpersonal, domiciliary or respite care.

4. The therapeutic supports available in the member's home community are insufficient to stabilize the member's current condition and a minimum of nine hours of treatment each week is required to treat the member's current condition safely and effectively.

5. The member is cognitively capable of actively engaging in the recommended treatment plan.

6. Active substance use disorder behavior within two weeks of the current treatment episode unless behavior has been prevented by incarceration or hospitalization.

7. The member's recovery environment and support systems are generally supportive of rehabilitation and the member can succeed in treatment with the intensity of current treatment services.

8. The members current condition reflects behavior(s)/psychiatric symptoms that result in functional impairment in 1 area, including but not limited to:
    a. Potential safety issues for either self or others
    b. Primary support
    c. Social/interpersonal
    d. Occupational/educational
    e. Health/medical compliance

9. This level of care is necessary to provide structure for treatment when at least one of the following exists:
    a. The member's office-based providers submit clinical documentation that the member requires the requested level of care secondary to multiple factors, including but not limited to, medical comorbidity with instability that impairs overall health, unstable living situations, a current support system engages in behaviors that undermine the goals of treatment and adversely affect outcomes, lack of community resources or any other factors that would impact the overall treatment outcome and community tenure.

    b. After a recent therapeutic trial, the member has a documented history of an inability to adhere to the treatment plan at an intensive lower level of care, being non-responsive to treatment or failing to respond to treatment with a reduction in symptom frequency,

duration or intensity that triggered the admission. Failure of treatment at a less intensive level of care is not a prerequisite for requiring benefit coverage at a higher level of care.

c. The member is at high risk for admission to a higher level of care secondary to multiple recent previous treatments that resulted in unsuccessful stabilization in the community post-discharge.

Note: intensive treatment is defined as at least weekly sessions of individual, family or group counseling

10. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care OR the member has current morbidity from substance use disorder, which requires regular medical evaluation and management.

11. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care AND these services are provided in a timely manner at the appropriate intensity.

Continued Care Criteria:
Must meet 1 – 10 and at least one of 11, 12 or 13: (criteria #5 should only be used when the member seeks treatment outside of their home geographic area and #6 only if there are multiple recent admissions)

1. A DSM diagnosis of substance use disorder, which is the primary focus of active treatment each program day.

2. There is a reasonable expectation for improvement in the severity of the current condition and behaviors that require a minimum of nine hours each week to provide treatment, structure, and support.

3. The treatment is not primarily social, interpersonal, domiciliary or respite care.

4. Family/support system coordination as evidenced by contact with family to discuss current treatment and support needed to transition and maintain treatment at lower levels of care.

5. If a member is receiving treatment outside of their geographic home, discharge planning proactively reflects and mitigates the higher risk of relapse associated with treatment away from home.

6. If a member has a recent history involving multiple treatment attempts with recidivism, the facility develops and implements a treatment plan focused on increasing motivation, readiness for change, relapse prevention interventions, facilitates the development of recovery supports and other services to benefit the member in his/her recovery process.

7. The program supports and helps the member to develop, acquire and utilize new learned skills to achieve sobriety in a real-world environment. Examples include but are not limited to:
    a. Confirmed attendance at outside recovery support meetings such as 12 Step, SMART Recovery, etc.
    b. Developing a temporary sponsor in the AA community.
    c. Attending vocational training or education outside the treatment facility.
    d. Actively seeking paid work or a volunteer position.
    e. Regular interactions with family, friends, children, and other identified supports
    f. Developing adaptive sober behaviors in their place of permanent residence.

8. The member is displaying increasing motivation, interest in, and ability to actively engage in his/her substance use disorder treatment, as evidenced by active participation in groups, cooperation with treatment plan, working on assignments, actively building a relapse prevention plan and other

markers of treatment engagement. If the member is not displaying increased motivation, there is evidence of active, timely reevaluation and treatment plan modifications to address the current condition.

9. The member's treatment plan is centered on the alleviation of disabling substance use disorder symptoms and precipitating psychosocial stressors. There is documentation of member progress towards objective, measurable treatment goals that must be met for the member to transition to the next appropriate level of care. If the member is not progressing appropriately or if the member's condition has worsened, there is evidence of active, timely reevaluation and treatment plan modifications to address the current needs and stabilize the symptoms necessitating the continued stay.

10. There is documentation that frequent attempts are made to secure timely access to all current and post-discharge treatment resources and housing (including alternative contingency plans) needed to adequately support timely movement to the next appropriate lower level of care.

11. There are acute psychiatric symptoms or cognitive deficits of mild intensity that require concurrent mental health treatment at the IOP level of care AND these psychiatric services are provided in a timely manner at the appropriate intensity.

12. Despite intensive therapeutic efforts, this level of care is necessary to treat the intensity, frequency and duration of current behaviors and symptoms. Subjective opinions that a member has an acute and imminent risk of decompensation are supported by confirmatory objective clinical evidence.

13. There is documentation of ongoing active medical issues secondary to substance use disorder that have the clear potential to precipitate significant medical care OR the member has current morbidity from substance use disorder requiring medical evaluation and management.

Note: Completing the program structure (fixed number of visits, waiting for family interventions, completion of step work, written autobiography, etc.) is not the sole reason for continued stay in the program.

When Substance Use Disorder Intensive Outpatient Programs is not covered

Treatment for Substance Use Disorder Intensive Outpatient Programs is considered not medically necessary when members do NOT meet ALL the criteria listed above in the When Treatment is Covered Section.

Policy Guidelines

Substance-related disorders, including dependence and addiction, are chronic conditions with recurrent cycles of misuse, recovery, and often, relapse. Assessment and treatment may be complicated by polysubstance use, comorbid psychiatric disorders, physiologic compromise (e.g., hepatitis, cirrhosis), lack of adherence with recommended medical therapy, accidental overdose, suicide, and exposure to violence. In many countries, substance-related disorders have been associated with longer lengths of medical hospital stays, higher hospitalization costs, and increased rates of readmission, as well as increased emergency department visits and psychiatric admissions.

Treatment of substance-related disorders, including dependence or withdrawal, nearly always can be conducted in an outpatient setting. Inpatient admission may be needed to manage severe alcohol or sedative withdrawal or to manage behavior in the setting of any substance-related disorder that presents an imminent risk of harm to the patient or others. A narrative review on the inpatient management of opioid use disorder states that hospitalization can serve as an opportunity to address addiction, identify, and intervene on psychosocial and mental health barriers, treat substance withdrawal, and propagate harm-reduction strategies. In the absence of imminently life-threatening medical or psychiatric conditions, treatment of patients with substance-related disorders may be

delivered in alternative treatment settings, such as residential care, partial hospital programs, or intensive outpatient care.

Residential care settings may be an option for voluntary patients who need inpatient care due to clinical urgency but do not require restraint. A longitudinal comparison of residential treatment outcomes among 292 young adults with opioid use disorders (18 to 24 years of age) found that at 6 months and 12 months, complete abstinence rates were 43% and 29%, respectively. Partial hospital programs may provide an option for patients with sufficient community support who do not require around-the-clock behavioral care. Partial hospital programs (also known as day hospitals) provide multidisciplinary behavioral care for 6 to 8 hours per day, 5 to 7 days per week, and are staffed in a manner similar to the day shift of an inpatient unit. Intensive outpatient programs typically provide 3 to 4 hours of psychosocial treatment, 1 to 4 days per week (usually 6 to 12 hours of treatment per week; a minimum of 6 hours per week for adolescents and 9 hours per week for adults generally is provided in intensive outpatient substance use programs), sometimes in a group format, and are intended for patients who need a type or frequency of treatment with demonstrated efficacy that is not available in a standard office or clinic setting. A systematic review of the use of intensive outpatient programs vs inpatient treatment of substance use and alcohol disorders reported that intensive outpatient programs produced benefits similar to those achieved by inpatient care. A review of the outpatient management of alcohol withdrawal supports the use of pharmacotherapy as appropriate and supportive care for patients with mild to moderate withdrawal symptoms who lack additional risk factors for developing severe or complicated withdrawal, with close clinician monitoring for up to 5 days after last alcohol use to ensure symptom improvement with treatment.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: H0015

Only one (1) unit for IOP on a facility or professional claim is allowed per date of service as these services are defined as per diem and includes all facility, professional, ancillary, and other services rendered to the member at the site.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. Cochrane Database of Systematic Reviews 2011, Issue 10. Art. No.: CD004147. DOI: 10.1002/14651858.CD004147.pub4

American Psychiatric Association. Practice guideline for the treatment of patients with substance use disorders, 2nd edition. In American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2006.

American Psychiatric Association (2006). Treating Substance Use Disorders: A Quick Reference Guide.

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th edition).

American Psychological Association. (n.d.). Depression Assessment Instruments. American Psychological Association. https://www.apa.org/depression-guideline/assessment/Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9. Journal of General Internal Medicine, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Anton RF, O'Malley SS, Ciraulo DA, Cisler RA, Couper D, Donovan DM, Gastfriend DR, Hosking JD, Johnson BA, LoCastro JS, Longabaugh R, Mason BJ, Mattson ME, Miller WR, Pettinati HM, Randall CL, Swift R, Weiss RD, Williams LD, Zweben A; COMBINE Study Research Group. 2006.

Arlington, VA: American Psychiatric Association, 2006 (pp. 291–563). Available online at http://www.psych.org/psych_pract/treatg/pg/SUD2ePG_04-28-06.pdf.

ASAM National Practice Guideline for the Treatment of Opioid Use Disorder 2020 Focused Update

ASAM Clinical Practice Guideline on Alcohol Withdrawal Management 23, 2020

Combined pharmacotherapies and behavioral interventions for alcohol dependence: the COMBINE study: a randomized controlled trial. JAMA 295(17):2003-17. PMID:16670409

Day E, Strang J. Outpatient versus inpatient opioid detoxification: a randomized controlled trial. Journal of Substance Abuse Treatment 2011;40(1):56-66. DOI: 10.1016/j.jsat.2010.08.007

Drug Misuse Opioid Detoxification. NICE Clinical Guidance CG52 [Internet] National Institute for Health and Care Execellence. 2007 Jul (NICE reviewed 2019) Accessed at: https://www.nice.org.uk/guidance.

Gupta A, et al. Opioid abuse or dependence increases 30-day readmission rates after major operating room procedures: a national readmissions database study. Anesthesiology 2018;128(5):880-890. DOI: 10.1097/ALN.0000000000002136.

Jorgensen KB, Nordentoft M, Hjorthoj C. Association between alcohol and substance use disorders and psychiatric service use in patients with severe mental illness: a nationwide Danish register-based cohort study. Psychological Medicine 2018;48(15):2592-2600. DOI: 10.1017/S0033291718000223

Kleber HD & Smith Connery H. (2007). Guideline Watch (April 2007): Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Edition. FOCUS: The Journal of Lifelong Learning in psychiatry V(2):1-4, Spring 2007.

Level of care placement. In: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, Provence SM, editors. ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013:174-306

Mangione, C. M., Barry, M. J., Nicholson, W. K., Cabana, M. D., Chelmow, D., Coker, T. R., Davidson, K. W., Davis, E. M., Donahue, K. E., Jaén, C. R., Kubik, M., Li, L., Ogedegbe, G., Pbert, L., Ruiz, J., Silverstein, M., Stevermer, J. J., & Wong, J. B. (n.d.).
Marshall M, Crowther R, Sledge WH, Rathbone J, Soares-Weiser K. Day hospital versus admission for acute psychiatric disorders. Cochrane Database of Systematic Reviews 2011, Issue 12. Art. No.: CD004026. DOI: 10.1002/14651858.CD004026.pub2.

Matching multidimensional severity and level of function with type and intensity of service. In: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, Provence SM, editors. ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013:69-104.

McCarty D, et al. Substance abuse intensive outpatient programs: assessing the evidence. Psychiatric Services 2014;65(6):718-726. DOI: 10.1176/appi.ps.201300249

McKetin R, Degenhardt L, Shanahan M, Baker AL, Lee NK, Lubman DI. Health service utilisation attributable to methamphetamine use in Australia: Patterns, predictors and national impact. Drug and Alcohol Review 2018;37(2):196-204. DOI: 10.1111/dar.12518.

North Carolina Department of Heath and Human Services; State-Funded Enhanced Mental Health and Substance Abuse Services, October 15, 2023 NCDMA: NC DMA: Title of Policy, Clinical Coverage Policy No. (ncdhhs.gov)

Reif S, et al. Residential treatment for individuals with substance use disorders: assessing the evidence. Psychiatric Services 2014;65(3):301-312. DOI: 10.1176/appi.ps.201300242.

Riedel, M., Möller, H., Obermeier, M., Schennach-Wolff, R., Bauer, M., Adli, M., Kronmüller, K., Nickel, T., Brieger, P., Laux, G., Bender, W., Heuser, I., Zeiler, J., Gäebel, W., & Seemüller, F. (2010). Response and remission criteria in major depression – A validation of current practice. Journal of Psychiatric Research, 44(15), 1063–1068. https://doi.org/10.1016/j.jpsychires.2010.03.006

Rosser J, Michael S. Partial Hospitalization Programs and Intensive Outpatient Programs. 2021 AABH Standards and Guidelines [Internet] Association for Ambulatory Behavioral Healthcare. 2021 Accessed at: https://aabh.org/.

Rowell-Cunsolo TL, Liu J, Hu G, Larson E. Length of hospitalization and hospital readmissions among patients with substance use disorders in New York City, NY USA. Drug and Alcohol Dependence 2020;212:107987. DOI: 10.1016/j.drugalcdep.2020.10798

Schuman-Olivier Z, Claire Greene M, Bergman BG, Kelly JF. Is residential treatment effective for opioid use disorders? A longitudinal comparison of treatment outcomes among opioid dependent, opioid misusing, and non-opioid using emerging adults with substance use disorder. Drug and Alcohol Dependence 2014;144:178-185. DOI: 10.1016/j.drugalcdep.2014.09.009.

Screening for Depression and Suicide Risk in Children and Adolescents. JAMA. https://doi.org/10.1001/jama.2022.16946

Service planning and placement. In: Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, Provence SM, editors. ASAM Criteria Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013:105-126.

Substance-related and addictive disorders. In: American Psychiatric Association, editor. Diagnostic and Statistical Manual of Mental Disorders. DSM-5-TR ed. American Psychiatric Association; 2022:543-666.

Medical Director Review 3/2024

Policy Implementation/Update Information

4/1/24	New policy developed. BCBSNC will provide coverage for Intensive Outpatient Programs (IOP) for Substance Use Disorder when it is determined to be medically necessary because the

medical criteria and guidelines listed within the policy are met. Medical Director review 3/2024. **Notification given on 4/1/2024 for effective date 7/1/2024.** (tt)