Clinical Review Criteria
Chemical Dependency – Residential Admission & Concurrent Stay

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Criteria
For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
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<tr>
<td>CMS Coverage Manuals</td>
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<tr>
<td>National Coverage Determinations (NCD)</td>
<td>Inpatient Hospital Stays for Treatment of Alcoholism (130.1) or Outpatient Hospital Services for Treatment of Alcoholism (130.2) or Chemical Aversion Therapy for Treatment of Alcoholism (130.3) or Electrical Aversion Therapy for Treatment of Alcoholism (130.4) or Treatment of Alcoholism and Drug Abuse in a Freestanding Clinic (130.5) or Treatment of Drug Abuse (Chemical Dependency) (130.6) or Withdrawal Treatments for Narcotic Addictions (130.7)</td>
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<tr>
<td>Local Coverage Determinations (LCD)</td>
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<td>Local Coverage Article</td>
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For Non-Medicare Members
Residential Admission & Concurrent Stay, Adult
Kaiser Permanente has elected to use the MCG* Substance-Related Disorders, Residential Behavioral Health Level of Care, Adult (B-KP-100-RES CON) for medical necessity determinations.

Residential Admission & Concurrent Stay, Child or Adolescent
Kaiser Permanente has elected to use the MCG*Substance-Related Disorders, Residential Behavioral Health Level of Care, Child or Adolescent (B-KP-105-RES ADLSCNT) for medical necessity determinations.

*The MCG are proprietary and cannot be published and/or distributed. However, on an individual member basis, Kaiser Permanente can share a copy of the specific criteria document used to make a utilization management decision. If one of your patients is being reviewed by our Behavioral Health department, you may request a copy of the criteria that is being used to make the coverage determination. Call the Behavioral Health Unit for more information regarding the case under review.

The following information was used in the development of this document and is provided as background only. It is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background
The purpose of the behavioral health medical necessity criteria is to provide a guide to coverage. Behavioral health policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their clinical judgment in providing the most appropriate care. To qualify for the chemical dependency benefit, members must have a DSM-IV diagnosis of substance dependence that is the primary reason for placement at the residential level of care.
Kaiser Permanente Behavioral Health Services operationally defines clinically indicated services as "services for mental health conditions that are having a clinically significant impact on an individual's social, medical, and/or occupational functioning."

**Adult Residential Treatment**

Substance use disorders are chronic medical problems associated with changes in the nervous system that require months of abstinence for recovery. Clinically, these diseases require long-term engagement in care to have the best outcomes for patients. Outcomes research over the past 27 years consistently finds that longer treatment duration leads to improved outcomes. This has led the Department of Veterans Affairs to set performance measures for substance use disorders treatment to continuing treatment for 90 days or more.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) of the National Institutes of Health (NIH) considers outpatient treatment to be the most promising course for those that are chemically dependent and, thus, the preferred care strategy. However, residential care does have a role in the continuum of treatment for patients with addictive diseases. When severe addictive disease and other co-morbidities are present, we believe it is important to provide residential care as a covered benefit for those patients who may need more intensive treatment. It should allow them to better engage in and benefit eventually from continued outpatient treatment, which is central to their recovery. As with other chronic health conditions, relapse is expected. Therefore, effective care plans include relapse prevention strategies as well as actions to take in the event of a relapse. Relapse does not constitute a need for residential treatment; rather, it supports the need for engagement or re-engagement in outpatient care and other support activities.

Current data reflects that 50% – 75% of patients with substance use disorders seeking treatment have co-occurring mental health conditions. Patients with co-occurring conditions are more likely to benefit from residential care. Effective treatment should optimally address both disorders via an integrated care plan. The care plan will help guide treatment in residential care and will inform transition and discharge planning related to follow-up needs.

Medical evaluation is often an important component of care. In addition to general medical conditions, attention needs to be given to assessing the patient’s need for detoxification. Medical assessment ideally includes evaluation of the patient’s eligibility for medications to assist with the medical management of cravings and/or opiate replacement treatment (if applicable).

**Adolescent Residential Treatment**

Residential treatment services are provided or authorized with the overall goals of assessing and stabilizing the member's severe symptoms, in order that treatment can be continued effectively in a less restrictive and disruptive level of care. Since substance use disorders are chronic disorders, treatment is optimally provided over longer periods of time. Residential treatment may serve as the level of care needed to help youths to stabilize and engage in treatment with the ultimate goal of transitioning to longer term treatment at a lower level of care.

Residential chemical dependency treatment is utilized when it is the most appropriate and effective level of care that can safely be provided for the member's immediate condition. Service authorization is based on the member’s contract and these clinical review criteria. When treating children or adolescents under the age of 18 in a residential treatment program, the parents or guardians must consent for the treatment and be included in both the evaluation and treatment planning processes, except for youths who have been living outside of the family home and the parents are unavailable, unable, or unwilling to provide consent to treatment. Admitting a self-consenting youth is a determination made by the program to which the youth applies, based on information obtained by the program, and the program must document efforts to locate and engage the parents in the treatment process.

Medical evaluation is often an important component of care. In addition to general medical conditions, attention needs to be given to assessing the youths need for detoxification, and ideally includes evaluation of the patients eligibility for medications to assist with the medical management of cravings, and/or opiate replacement treatment (if applicable).

**ASAM placement criteria for both adult and adolescents**

Washington State requires the use of ASAM criteria by State-certified chemical dependency treatment providers, when determining placement of patients with substance use disorders (criteria includes placement recommendations related to residential treatment). Clinical recommendations must be documented in writing and must contain objective clinical information. Clinical criteria do not factor in family, employer or legal mandates or requests for treatment. Clinical criteria are intended to evaluate the impact of the substance use disorder on the affected individual (via a bio-psychosocial assessment) and to guide decision making related to care strategies.
Evidence and Source Documents

References for Adult Residential Treatment:
   This study was a data analysis from the Services Research Outcomes Study, surveying 3,047 clients in 99 drug treatment facilities across the United States. No long-term differences in abstinence or reduced drinking between outpatient treatment and residential treatment. Outpatient treatment was the most cost-effective treatment modality.

   This study was a randomized controlled trial of 668 adults entering drug treatment in an HMO (Kaiser) randomized to day hospital treatment or to outpatient treatment. Patients randomized to either outpatient or day hospital treatment fared equally well. Patients with mid-level psychiatric severity did fare better with the higher level of care.

   This study was a randomized controlled trial of 293 adults entering substance abuse treatment in an HMO (Kaiser) randomized to day hospital treatment or to residential treatment. Despite differences in baseline severity between groups, patients randomized or non-randomized fared equally well in either treatment intensity. 12 month outcomes were most closely related to continued 12-step participation.

   This study was a randomized controlled trial of adults entering substance abuse treatment in an HMO (Kaiser) randomized to hospital-based day treatment or to one of two community-based day treatment programs. Patients randomly assigned to either hospital-based day treatment or community-based treatment fared equally well, while costs were lower in community-based programs.

   This study extends similar findings from a report on 6-month outcomes from a randomized trial assigning 188 clients entering a therapeutic community to either day treatment or residential treatment. Both groups had similar improvements over time with those in residential treatment having greater improvement for psychiatric symptoms and social problems.

   This study was a naturalistic study following 473 alcoholic adults over 8 years following SUD identification. Rapidly entering treatment and duration of treatment (i.e., longer duration being better) were related to better short and long-term (i.e., 3 and 8 year) alcohol-related outcomes. In general, intensity of treatment was not related to better outcomes.

   This study evaluated a patient-treatment matching strategy for dual-diagnosis patients in the VA (N=230). Patients with high severity dual disorders had better alcohol, drug and psychiatric outcomes and higher health care costs. Moderate severity patients generally had similar outcomes whether they were matched to low-intensity treatment or not.

References for Adolescent Residential Treatment:
2. This paper summarizes the findings in adolescent substance abuse treatment with occasional comparisons to adult substance abuse and treatment. There is little evidence to guide selection of treatment modality or
setting in adolescents. There are some differences between substance use disorders in adolescents and adults, notably, adolescents typically have less motivation for abstinence than adults.

3. Hser YI, Grella C, Hubbard RL, Hsieh SC, Fletcher BW, Brown BS, Anglin MD. “An Evaluation of Drug Treatments for Adolescents in 4 US Cities.” Archives of General Psychiatry. 58:689-695; 2001. This was a naturalistic study of 1167 adolescents who were treated in one of three different treatment settings and followed for one year. This study did not compare treatment settings with one another, but in general, found treatment in all settings to lead to improvements in most substance use and overall functioning domains and that length of time in treatment is associated with better outcomes.

4. Grella C, Hser YI, Joshi V, Rounds-Bryant J. “Drug Treatment Outcomes for Adolescents with Comorbid Mental and Substance Use Disorders.” Journal of Nervous and Mental Disease. 189(6): 384-392; 2001. A naturalistic study of 992 adolescents treated in three different treatment settings compared those with and without comorbid psychiatric disorders. Psychiatric comorbidity was associated with greater substance use problems entering treatment, which was associated with less favorable treatment outcomes. Compared to those without comorbidity, comorbid youth were more likely to use cannabis and hallucinogens and were more likely to engage in illegal acts a year after treatment.


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MDCRPC: Medical Director Clinical Review and Policy Committee
MPC: Medical Policy Committee

Revision History

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MPC approved to adopt hybrid (MCG/KP) criteria

Codes