# Select Health Medical Policies

## Behavioral Health Policies

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MEDICAL POLICY

# APPLIED BEHAVIOR ANALYSIS (ABA)

Policy # 630
Implementation Date:3/14/19
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**Disclaimer:**
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

Autism Spectrum Disorder (ASD) is usually first diagnosed in childhood at 18 months with many of the most-obvious signs presenting around 2–3 years old, but some children with autism develop normally until toddlerhood when they stop acquiring or lose previously gained skills. According to the CDC, one in 36 children is estimated to have autism. ASD is also three to four times more common in boys than in girls, and many girls with ASD exhibit less obvious signs compared to boys. Autism is a lifelong condition; however, many children diagnosed with ASD go on to live independent, productive, and fulfilling lives. Autism differs from person to person in severity and combinations of symptoms. There is a significant range of abilities and characteristics of children with ASD—no two children appear or behave the same way—symptoms can range from mild to severe and often change over time.

Practitioners of applied behavior analysis (ABA) aim to improve socially important behavior by using interventions that are based upon principles of learning theory and that have been evaluated in experiments using reliable and objective measurement. ABA methods are intended to support individuals with autism spectrum disorder in many ways:

- To increase behaviors (e.g., to increase on-task behavior, or social interactions) and to teach new skills (e.g., life skills, communication skills, or social skills).
- To maintain behaviors (e.g., self-control and self-monitoring procedures to maintain and generalize job-related social skills).
- To generalize or to transfer behavior from one situation or response to another (e.g., from completing assignments in the resource room to performing as well in the mainstream classroom).
- To restrict or narrow conditions under which interfering behaviors occur (e.g., modifying the learning environment).
- To reduce interfering behaviors (e.g., self-injury or stereotypy).

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage, state specific requirements, essential elements, and medical necessity at the time of the request.

### FEHB Exceptions – ABA Therapy

Effective July 1, 2025, FEHB subscribers/members newly receiving ABA therapy on or after this date are subject to the criteria outlined in the current ABA medical policy (see below*).

- FEHB subscribers/members who began receiving ABA therapy on or before June 30, 2025, are subject to the previous ABA medical policy (see below**).

- Child dependents who begin ABA therapy on or after July 1, 2025, but who have FEHB-enrolled siblings already receiving ABA therapy, are grandfathered under the previous ABA medical policy. Therefore, they are not subject to the criteria outlined in the current policy.

****Previous version of medical policy #630 (was effective through June 30, 2025)**

**Select Health considers Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder** medically necessary when ALL the following criteria are met:

Criteria for ABA Therapy:

1. The member is at least 18 months of age;
2. The member meets criteria for a diagnosis of pervasive developmental disorder, not otherwise specified (PDD, nos), or autism spectrum disorder (ASD), or Asperger's, according to the Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5).
3. Diagnosis and treatment are provided by an appropriate behavioral healthcare professional.
4. The member demonstrates clinical improvement within 3 months of starting ABA therapy for continued therapy to be covered.

**Select Health considers ABA therapy experimental/investigational** for all other indications due to lack of clinical literature/studies proving efficacy.

***Current ABA medical policy (Effective July 1, 2025)**

**A. Essential Elements and Medical Necessity to qualify for ABA:**

1) DSM-V diagnosis of Autism Spectrum Disorder (ASD) (ICD-10/ F84.0; F84.3 – F84.9) obtained by an appropriate licensed provider who is board certified in neurology, psychiatry, or pediatrics or other licensed psychologist/psychiatrist, physician, or other healthcare professional qualified to diagnose mental health conditions within their scope of practice in their state of license (member state).
2) There are identifiable target behaviors having an impact so the member cannot adequately participate in developmentally appropriate activities such as school; or there may be a significant risk of harm to self or others. ABA treatment is not custodial in nature: which can be defined as care provided when the member may have reached the maximum level of physical or mental function and such member is not likely to make further significant improvement; or any type of care where the primary purpose of the care provided is to attend to the member's daily living activities, which do not require the continued attention of trained medical professionals.
3) There is an individualized treatment plan developed that is based on individual needs.
   a) The treatment plan responses meet the following:
      i. Member-centric
      ii. Identifies strengths and needs of member's behavior
      iii. Identifies clearly defined Parent/Family/Caregiver/Guardian goals designed to teach the basic behavioral principles of ABA and support continuation of behavioral interventions in the home and community
      iv. Community-based treatments are optimized (e.g., school engagement and cooperation)
      v. Staff are identified to work with the member
      vi. Date that services are scheduled to start
   b) The treatment plan has specific target behaviors that are clearly defined according to the following:





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i. Initial comprehensive assessment of specific behaviors at baseline that through meaningful treatment goals will be improved over the course of the established treatment plan.
ii. Baseline for each treatment goal is established through objective measures.
iii. Symptoms, intensity, duration, or other objective measures of baseline levels are recorded
iv. Quantifiable criteria for progress are established
v. Quantifiable criteria for target mastery are established

c) The treatment plan describes behavioral intervention techniques appropriate to the target behavior(s), reinforcers selected, and strategies for generalization of learned skills are specified

4) There is documentation of planning for transition through the continuum of interventions, services, and settings, as well as specific fading and discharge criteria.
5) There is engagement and commitment from Parent/Family/Caregiver/Guardian to participate in treatment to generalize and support gains.
6) There is a plan to collect and demonstrate Parent/Family/Caregiver/Guardian progress toward meeting identified training goals.
7) There is a review of the member's history as well as ongoing attempted collaboration and coordination with existing providers and/or the school district, as applicable. There is involvement of, or referrals to, appropriate healthcare, community or supplemental resources.
8) ABA services must be provided directly or supervised by licensed behavior analysts (in states with Behavior analyst licensure laws), board-certified behavior analysts, or licensed psychologists where behavior analysis is within their scope of practice definition, unless state mandates, plan documents or contracts require otherwise. If state mandates, plan documents or contracts allow authorization for services that are not directly provided by individuals licensed by the State or certified by the Behavior Analyst Certification Board as noted above, there must be Supervision and direction of the unlicensed or non-certified providers in line with practice standards, unless state mandates, plan documents or contracts require otherwise.
9) Services should be supervised at a minimum of 5% of direct service hours and should be supervised at least monthly.
10) The table below will allow for guidance for standardized assessment units in evaluating ABA therapy.

| **Assessment units (Guide): Billing/Coding Information** | |
|---|---|
| **Functional Analysis:** A type of functional assessment that involves the direct manipulation of antecedents and/or consequences to identify why problem behavior occurs. | 8-16 units* |
| **Focused:** Focused treatment can be ideal in situations where symptoms of autism are not a constant issue, but there are one or two areas that require targeted intervention. | 16- 24 units |
| **Comprehensive:** Comprehensive programs are provided in situations where the child with autism needs intensive intervention to successfully navigate their environment and to learn. | 32 units |

*1 unit = 15 minutes

11) Calculated using the guide below, the requested units of service and intensity of treatment reflect the severity of impairments, goals of treatment, and response to treatment across all settings and environments where treatment will occur.
a) The level of impairment justifies the number of hours requested for ABA

| **Intensity Of Treatment and Severity of Symptoms (Guide to Approval as defined: Billing/Coding Information)** | | | | |
|---|---|---|---|---|
| | **None** <1 SD below | **Mild** >1 SD below | **Moderate** >1.5 SD below | **Severe** >2 SD below |





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| | 0 hours per week | 1 to 4 hours per week | 4 to 7 hours per week | 7 to 10 hours per week |
|---|---|---|---|---|
| **Maladaptive Behavior:** aggression, self-injury, property destruction, restrictive/repetitive behaviors and interests; abnormal, inflexible, or intense preoccupations | | | | |
| **Social Communication:** Problems with expressive or receptive language, poor understanding or use of non-verbal communications, stereotyped or repetitive language, lack of social/emotional reciprocity, failure to seek or develop shared social activities | | | | |
| **Self-Care:** Difficulty recognizing danger/risks, or advocating for self; problems with grooming/eating/toileting skills which are impeded by symptoms of ASD | | | | |
| Based on functional impairment and assessment of symptom severity, additional authorization may be provided for QHP protocol modification and direction at 1 to 2 hours per 10 hours of treatment by protocol. | | | | |
| Authorization for caregiver training in **Clinically Approved Dosage**: The amount of training should be based on clinical recommendations and the needs of the caregiver and the individual | | | | |

**B. <u>Initiation of ABA treatment meets the following:</u>**

1) Essential Elements listed above are met
2) Initiation of Applied Behavior Analysis (ABA) may be considered medically necessary when both of the following criteria are met:
   a) ABA must be recommended or prescribed by a qualified treating healthcare professional experienced in the diagnosis and treatment of ASD, as defined by state law.
   b) Parent/Family/Caregiver/Guardian will be provided with necessary support and training to reinforce interventions and generalize gains.

**<u>C. Continuation of ABA treatment requires all the following to be met:</u>**

1) Essential Elements continue to be met
2) Continued authorization is adjusted (up or down) based on clinical review of medical necessity including Intensity of treatment and severity of symptoms to occur up to every 6 consecutive months.
3) The frequency of the target behavior has improved since the last review, with the treatment plan documenting a gradual tapering of treatment intensity and a shift to support from other sources as progress is made, or if not, the treatment has been modified, additional assessments conducted, and consultations with experts have occurred,
4) The treatment plan should be reviewed and updated regularly to ensure it remains effective and tailored to the individual's need, allowing for progress monitoring and adjustments as needed to meet the individual's goals, prevent regression, or maintain functional gains
   a) Significant Changes or Lacking Progress: If there are major changes in the individual's behavior, environment, or health, or little to no progress on goals, the treatment plan should reflect a relevant review and be updated accordingly
   b) The plan of care has been updated utilizing validated scales (e.g. Vineland Adaptive Behavior Scales 3 (VABS-3), the Adaptive Behavior Assessment Scale (ABAS), VB-MAPP, or ABLLS)
5) Parent/Family/Caregivers/Guardians continue with education and training to understand and implement treatment strategies at home to help ensure consistency and reinforce the skills being taught in therapy
6) Documented collaboration among various stakeholders, including family caregivers, pediatric providers, school psychologists, and behavioral analysts, in the treatment planning and review process.

7) Evidence member is encouraged to obtain periodic exams from other professionals. Examples of other professionals include well visit, medical exam, dental exam, hearing screen, speech and language evaluation.
   a) ABA treatment is not a substitute for physical treatments, occupational therapies or other medical or behavioral health services.

**D. Discontinuation of Services**

1) Continued services are considered not medical necessary when at least one of the following criteria are met:
   a) The Essential Elements are no longer met.
   b) Parent/Family/Caregiver/Guardian have not participated in treatment for successive authorization periods.
   c) The member has achieved treatment goals or has not demonstrated progress for successive authorization periods.

**E. Definitions**

Either focused or comprehensive treatment will be allowed unless state mandates say otherwise.

**Comprehensive** ABA refers to treatment provided directly to the patient to improve or maintain behaviors in many skill areas across multiple domains (e.g., cognitive, communicative, social, behavioral, adaptive). Treatment often emphasizes establishing new skills but may also focus on reducing challenging behaviors, such as elopement, and stereotypy, among others. Access to comprehensive ABA should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions.

**Focused** ABA refers to treatment, provided directly to the patient, to improve or maintain behaviors in a limited number of domains or skill areas. Access to focused intervention should not be restricted by age, cognitive level, diagnosis, or co-occurring conditions.

## SELECT HEALTH MEDICARE (CMS)

**Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies.** For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

## SELECT HEALTH COMMUNITY CARE (MEDICAID)

**Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used.** For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

**Summary of Medical Information and Relevant References**

**From the NIMH (National Institute of Mental Health)**
The diagnostic category of Autism Spectrum Disorder (ASD) refers to delays in the development of socialization and communication skills and can present with a wide range of symptoms and severity. Children with ASD vary widely in abilities, intelligence, and behaviors. Some children do not speak at all, others speak in limited phrases or conversations, and some have relatively normal language development. Repetitive play skills and limited social skills are generally evident. Unusual responses to sensory information, such as loud noises and lights, are also common. Parents may note symptoms as early as infancy, although the typical age of onset is before 3 years of age. Symptoms may include problems with using and understanding language; difficulty relating to people, objects, and events; unusual play with toys and other objects; difficulty with changes in routine or familiar surroundings, and repetitive body movements or behavior patterns.





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**Applied Behavioral Analysis**
**Research Summary**

Many studies show that ABA is effective in increasing behaviors and teaching new skills (National Autism Center [NAC], 2015; Wong et al., 2014, 2015). In addition, many studies demonstrate that ABA is effective in reducing problem behavior (NAC, 2015). A number of studies also indicate that, when implemented intensively (more than 20 hours per week) and early in life (beginning prior to the age of 4 years), ABA may produce large gains in development and reductions in the need for special services (Reichow, 2012); however, large studies with strong experimental designs are needed to confirm the results reported for intensive, early intervention. The United States Surgeon General (1999) concluded, "Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning and appropriate social behavior."

**CASP Recommendation of ABA**
Medically Necessary Treatment: Applied Behavior Analysis (ABA) is often considered medically necessary for individuals with Autism Spectrum Disorder (ASD). This determination is based on guidelines from organizations like the Behavior Analyst Certification Board (BACB) and the Council of Autism Service Providers (CASP), which emphasize the importance of ABA in addressing the functional impairments associated with ASD

The Council of Autism Service Providers (CASP) guidelines focus on the effective use of Applied Behavior Analysis (ABA) for treating Autism Spectrum Disorder (ASD). Key points include:

- Evidence-Based Practices: Guidelines are based on scientific evidence and expert opinion.
- Stakeholder Collaboration: Emphasizes collaboration among healthcare funders, regulatory bodies, service providers, and consumers.
- Standards of Care: Detailed standards for planning, implementing, and evaluating ABA services.
- Organizational Guidelines: Best practices for organizations providing evidence-based services.
- Parent Collaboration: Parents are considered essential members of the treatment team, contributing valuable insights and participating in decision-making processes. Regular communication is encouraged to monitor progress and adjust the treatment plan.

CASP guidelines also stress a comprehensive assessment, behavioral goals, collaboration with the individual and guardians, and practical focus on behavior improvement. Additionally, they emphasize the importance of direct observational data, individualized treatment plans, frequent analysis, and caregiver training to support consistency and progress.

**Autism Spectrum Disorder/DSM-5 Criteria**

**Developmental Screening**
Developmental screening is a short test to tell if children are learning basic skills when they should, or if they might have delays. During developmental screening, the doctor might ask the parent some questions or talk and play with the child during an exam to see how she learns, speaks, behaves, and moves. A delay in any of these areas could be a sign of a problem.

All children should be screened for developmental delays and disabilities during regular well-child doctor visits at:

- 9 months
- 18 months
- 24 months or 30 months

Additional screening might be needed if a child is at high risk for developmental problems due to pre-term birth, low birth weight, or other reasons.

In addition, all children should be screened specifically for ASD during regular well-child doctor visits at:

- 18 months
- 24 months

Additional screening might be needed if a child is at high risk for ASD (e.g., having a sister, brother, or other family member with ASD), or if behaviors sometimes associated with ASD are present.
Characteristics of autism spectrum disorder fall into different categories.

- **Social interaction and communication problems:** including difficulties in normal back-and-forth conversation, reduced sharing of interests or emotions, challenges in understanding or responding to social cues such as eye contact and facial expressions, deficits in developing/maintaining/understanding relationships, and others.
- **Difficulty relating to people, things, and events:** including trouble making friends and interacting with people, difficulty reading facial expressions, and not making eye contact.
- **Restricted and repetitive patterns of behaviors, interests, or activities:** hand-flapping and toe-walking, playing with toys in an uncommon way (such as lining up cars or flipping objects), speaking in a unique way (such as using odd patterns or pitches in speaking or "scripting" from favorite shows), having significant need for a predictable routine or structure, exhibiting intense interests in activities that are uncommon for a similarly aged child, experiencing the sensory aspects of the world in an unusual or extreme way (such as indifference to pain/temperature, excessive smelling/touching of objects, fascination with lights and movement, being overwhelmed with loud noises, etc.), and others.

Also, while many people with autism have normal intelligence, many others have mild or significant intellectual delays. Also, those with ASD are at greater risk for some medical conditions such as sleep problems, seizures, and mental illnesses. Early diagnosis and treatment are important to reducing the symptoms of autism and improving the quality of life for people with autism and their families. There is no medical test for autism, it is diagnosed based on observing how the child talks and acts in comparison to other children of the same age. Trained professionals typically diagnose autism by talking with the child and asking questions of parents and other caregivers.

If there are concerns that an infant or toddler is not developing normally, it is important to share that concern with a primary care provider. The Centers for Disease Control and Prevention (CDC) have identified possible red flags for ASD in young children, including:

- Not responding to his/her name by 12 months of age
- Not pointing at objects to show interest by 14 months
- Not playing "pretend" games by 18 months
- Avoiding eye contact or preferring to be alone
- Getting upset by minor changes
- Flapping their hands, rocking their body, or spinning in circles
- Having unusual and sometimes intense reactions to the way things smell, taste, feel and/or look

Screening: All children should be screened for ASD with an autism-specific tool at the 18-month, and 24- or 30-month, well-child visits. [Johnson: 2007] Re-screening children after the 18-month visit is important since 1:4 children with ASD can have regression, especially in language skills, around 18–24 months of age. [Soares: 2012] While earlier identification of ASD is possible, autism-specific screening tools have not been validated for children younger than 18 months. Autism-specific screening tools are described below.

**Modified Checklist for Autism in Toddlers – Revised, with Follow-Up (M-CHAT-R/F):** The new MCHAT-R/F (released in 2013) is a free, 2-step tool that is more accurate than the previously used M-CHAT. It screens for autism from 16–30 months of age using a 20-item parent questionnaire that stratifies children's risk for autism and may include a follow-up interview in the office or over the telephone.
This typically involves an interview and play-based testing with a child done by a psychologist, developmental-behavioral pediatrician, child psychiatrist, or other providers. One of the most important changes in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is to ASD. The revised diagnosis represents a new, more accurate, and medically and scientifically useful way of diagnosing individuals with ASD and autism-related disorders:

**A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive):**

- Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
- Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
- Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

*Note:* Specify current severity: Severity is based on social communication impairments and restricted repetitive patterns of behavior (see table below).

**B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive):**

- Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
- Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
- Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or persevering interest)
- Hyper- or hypo-reactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

*Note:* Specify current severity: Severity is based on social communication impairments and restricted repetitive patterns of behavior (see table below).

**C. Symptoms must be present in the early developmental period (but may not become fully manifested until social demands exceed limited capacities or may be masked by learned strategies in later life).**

**D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.**

**E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and ASD frequently co-occur; to make comorbid diagnoses of ASD and intellectual disability, social communication should be below that expected for general developmental level.**

***Note:*** *Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder (not otherwise specified) should be given the diagnosis of ASD. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for ASD, should be evaluated for social (pragmatic) communication disorder.*

*Specify if:*
**- With or without accompanying intellectual impairment**
**- With or without accompanying language impairment**
**- Associated with a known medical or genetic condition or environmental factor**
(Coding note: Use additional code to identify the associated medical or genetic condition.)
**- Associated with another neurodevelopmental, mental, or behavioral disorder**
(Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral

disorder[s].)
**- With catatonia**
(Coding note: Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Table: Severity Levels for ASD

| Severity Level | Social Communication | Restricted, Repetitive Behaviors |
|---|---|---|
| Level 3 (requiring very substantial support) | Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches | Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action. |
| Level 2 (requiring substantial support) | Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication. | Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action. |
| Level 1 (requiring support) | Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who can speak in full sentences and engages in communication but whose to-and-from conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful. | Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence |

## Billing/Coding Information

*Covered for the conditions outlined above when criteria are met*

## CPT CODES

**0362T** Behavior identification supporting assessment, each 15 minutes of technicians' time, face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.

**0373T** Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior

**96202** Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes.

**96203** Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present),

face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service)

**97151** Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.

**97152** Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes

**97153** Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professionals, face-to-face with one patient, each 15 minutes

**97154** Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes

**97155** Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professionals, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

**97156** Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.

**97157** Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professionals (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes

**97158** Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professionals, face-to-face with multiple patients, each 15 minutes

**Key References**

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Select Health

**Revision History**

| Revision Date | Summary of Changes |
|---|---|
| 7/1/25 | For Commercial Plan Policy, comprehensively updated criteria for coverage, and included language regarding exceptions for members on FEHB plans. |

**Disclaimer**

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate healthcare providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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MEDICAL POLICY

# CHEMICAL AVERSION THERAPY FOR TREATMENT OF SUBSTANCE ABUSE

Policy # 573
Implementation Date:1/18/17
Review Dates: 12/21/17, 12/13/18, 12/18/19, 12/17/20, 11/22/21, 11/9/22, 12/19/23, 12/17/24
Revision Dates:

**Related Medical Policies:**
#582 Intermediate Levels of Care Utilization in Behavioral Health

**Disclaimer:**
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

Chemical aversion therapy is a behavior modification technique that is used in the treatment of alcoholism and other substance abuse disorders. Chemical aversion therapy facilitates substance abuse abstinence through the development of conditioned aversions to the taste, smell, and sight of alcohol, cannabis, and cocaine. This is accomplished by repeatedly pairing these substances with unpleasant symptoms (e.g., nausea) which have been induced by one of several chemical agents. While several drugs have been employed in chemical aversion therapy, the three most used are emetine, apomorphine, and lithium. None of the drugs being used, however, have yet been approved by the Food and Drug Administration specifically for use in chemical aversion therapy for substance abuse. Accordingly, when these drugs are being employed in conjunction with this therapy, patients undergoing this treatment need to be kept under medical observation.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

**Select Health covers chemical aversion therapy for the treatment of alcoholism and similar substance use disorders** as part of a coordinated treatment plan that includes therapy and support.

## SELECT HEALTH MEDICARE (CMS)

**Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies.** For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

## SELECT HEALTH COMMUNITY CARE (MEDICAID)

**Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used.** For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool





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## Chemical Aversion Therapy for Treatment of Substance Abuse, continued

### Summary of Medical Information

Frawley et al. (1992) studied 214 randomly selected patients treated with aversion therapy for cocaine dependence in four chemical dependency units operated by Schick Shadel Hospitals. Of these, 156 were followed up 12 to 20 months post-treatment (average 15.2 months). One-year total abstinence from alcohol was 54% for those receiving aversion for both alcohol and cocaine and 77% for those receiving aversion for alcohol, cocaine, and marijuana. Current abstinence from alcohol at follow-up was 68% and 81%, respectively. Results showed that 1-year total abstinence from marijuana was 42% for those treated with aversion for cocaine and marijuana, and 64% for those treated with aversion for alcohol, cocaine, and marijuana, while current abstinence at follow-up from marijuana was 61% and 81%, respectively. The results illustrated that total abstinence from cocaine for the group overall was 53% at one-year post-treatment, current abstinence of at least 6 months at follow-up was 68.6%, while those treated with aversion for cocaine alone had a one-year abstinence of 39% and a current abstinence of 62.4%. Study participants treated with aversion for alcohol and cocaine had a one-year total abstinence from cocaine of 69% and a current abstinence of 76%. Those treated with aversion for cocaine and marijuana had a one-year total abstinence from cocaine of 50% and a current abstinence of 65%. Those treated with aversion for alcohol, cocaine, and marijuana had a one-year total abstinence from cocaine of 73% and a current abstinence of 73%. The authors noted that the use of aversion therapy for both alcohol and cocaine in alcoholics who were also using cocaine was associated with higher total abstinence rates (88% vs. 55%) from cocaine when compared with alcoholics who used cocaine but received no aversion as part of their program. They further noted that the conclusion is tentative since the follow-up rate in this study was lower than that of the previous study (64% vs. 84%) and that being around other users accounted for 49% of relapse situations while family/work stress was associated with relapse in 33% of cases and unpleasant feelings in 24% of cases. The use of both reinforcement treatments and the use of support following treatment were associated with improved abstinence rates from cocaine while those patients who reported losing all urges for cocaine after treatment had a total abstinence from cocaine of 90%, those who reported losing all the uncontrollable urges had a total abstinence of 64%, and those who reported still having the urge reported only 33% total abstinence from cocaine.

Diana et al. (2008) reported that ethyl alcohol (EtOH), the main psychoactive ingredient of alcoholic drinks, is widely considered responsible for alcohol abuse and alcoholism through its positive motivational properties, which depend at least partially on the activation of the mesolimbic dopaminergic system. They further noted that acetaldehyde (ACD), EtOH's first metabolite, has been classically considered aversive and useful in the pharmacologic therapy of alcoholics. The authors illustrated that EtOH-derived ACD is necessary for EtOH-induced place preference, a preclinical test with high predictive validity for reward liability and that ACD is essential for EtOH-increased microdialysate dopamine (DA) levels in the nucleus accumbens (NAcc), and that this effect is mimicked by ACD administration to the intraventral tegmental area (VTA). The authors state that these results provide in vivo and in vitro evidence for a key role of ACD in EtOH motivational properties and its activation of the mesolimbic DA system. They further noted that these observations suggest that ACD would oppose its well-known peripherally originating aversive properties by increasing VTA DA neuronal activity. These findings could help in devising new effective pharmacologic therapies in alcoholism.

Cassiaglia et al. (2013) reported that people at high risk for alcoholism show deficits in aversive learning, as indicated by impaired electrodermal responses during fear conditioning, a basic form of associative learning that depends on the amygdala. They also state that positive family history of alcohol dependence has been related to decreased amygdala responses during emotional processing. This study reported that reduced amygdala activity during the acquisition of conditioned fear in healthy carriers of a risk variant for alcoholism (rs2072450) in the NR2A subunit-containing N-methyl-d-aspartate (NMDA)-receptor. The authors noted results indicate that rs2072450 might confer risk for alcohol dependence through deficient fear acquisition, indexed by a diminished amygdala response during aversive learning, and provide a neural basis for a weak behavioral inhibition previously documented in individuals at high risk for alcohol dependence.

Kim et al. (2014) noted that episodes of alcohol consumption produce use-limiting aversive effects as well as use-promoting euphoric effects and that the brain regions associated with the reward circuit in patients with alcohol dependence show signs of conditioning for alcohol craving. Kim et al. (2014) also noted that brain structures in the medial temporal region are known to be crucial for aversive conditioning. This study was conducted to compare differences in patterns of brain activation in response to cues that induce cravings versus aversion in alcohol dependence in 38 alcohol-dependent and 26 healthy

## Chemical Aversion Therapy for Treatment of Substance Abuse, continued

volunteers who were administered cue reactivity tasks while undergoing functional magnetic resonance imaging (fMRI) to examine brain response to craving-inducing cues (CIC) and aversion-inducing cues (AIC). The authors found that the right medial frontal gyrus (right orbitofrontal cortex) during CIC was greater in alcohol-dependent study participants than in healthy volunteers. Participants in the alcohol dependence group displayed less activation in the right amygdala and the right middle temporal gyrus during AIC than did the healthy volunteers and brain reactivity within the right medial frontal gyrus in response to CIC was positively correlated with the scores of alcohol dependent participants on the Korean Alcohol Urge Questionnaire (AUQ-K) and the Michigan Alcohol Screening Test (MAST). Reactivity within the amygdala in response to AIC was negatively correlated with AUQ-K scores among alcohol-dependent patients. The authors concluded that the dysfunction of the orbitofrontal cortex that results from repeated exposure to alcohol accounts for craving and relapse in alcohol-dependent subjects. Additionally, alcohol-dependent subjects seem to be less sensitive to cues related to aversive consequences of alcohol overuse in comparison with healthy individuals.

### Billing/Coding Information

**CPT CODES**

| | |
|---|---|
| **90899** | Unlisted psychiatric service or procedure |

**HCPCS CODES**

No specific codes identified

**Key References**


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MEDICAL POLICY

# EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Policy # 541
Implementation Date:10/17/13
Review Dates: 10/23/14, 10/15/15, 10/20/16, 10/19/17, 10/15/18, 10/15/19, 10/15/20, 11/22/21, 9/15/22, 10/16/23, 10/14/24
Revision Dates:12/30/20

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2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (Medicare), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

Eye movement desensitization and reprocessing (EMDR) therapy is a complex method of psychotherapy that combines a range of therapeutic approaches with eye movements or other forms of rhythmical stimulation (e.g., sound and touch) in ways that stimulate the brain's information processing system. Eye movement desensitization and reprocessing was introduced in 1989 as a treatment for post-traumatic stress disorder (PTSD). The underlying principle of desensitization is that prolonged exposure to a fear-inducing stimulus gradually reduces the cognitive and physiological symptoms of anxiety. The therapist provides reassurance and/or instructs the patient to use techniques that reduce anxiety (e.g., relaxation, coping techniques) during exposure to the event. The patient's negative emotional responses to memories of the trauma are thus reduced, resulting in reduction or elimination of the symptoms of PTSD.

Treatment of PTSD is similar to that of other anxiety disorders and includes medication and psychotherapy. The psychotherapies used for PTSD are typically cognitive-behavioral therapies (CBT) and include stress management training, in which the patient is taught to manage anxiety through relaxation; cognitive restructuring, in which the therapist helps the patient change distorted thoughts and beliefs; and systematic desensitization, in which the patient is gradually exposed to aspects of the traumatic event under the guidance of a therapist.

EMDR was developed as a method to treat PTSD using exposure and cognitive restructuring, in a relatively short time and without exposing the patient to prolonged anxiety. Patients are instructed to identify a target traumatic memory, articulate a negative statement that is associated with the memory (e.g., "I am helpless"), and formulate a positive statement to replace the negative one (e.g., "I am in control"). The patient engages a series of saccadic bilateral eye movements by following the therapist's fingers that move rapidly across the patient's field of vision. After each set of 10 to 20 eye movements, the patient is instructed to mentally "remove" the traumatic image, and rate distress and belief in the negative and positive cognition. In addition to general principles of cognitive behavioral therapies, several mechanisms of action have been proposed for EMDR, specifically, including a conditioning process in which the eye movements serve an accelerating function, and activation of a neurobiological substrate that modulates emotional responses, resulting in a homeostatic process.

Since its initial application in PTSD, EMDR has been proposed as a treatment of various psychiatric and behavioral disorders, including phobias, panic and anxiety disorders, and eating disorders.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

**Select Health covers eye movement desensitization and reprocessing for post-traumatic stress disorder (PTSD) only.**

**Select Health does NOT cover eye movement desensitization and reprocessing for all other indications** (including those listed below) because its effectiveness for indications other than PTSD has not been established; all other conditions for EMDR would be considered experimental/investigational.

1) Prevention of PTSD

2) Treatment of chronic phantom limb pain

3) Treatment of panic and anxiety disorders (other than PTSD)

4)Treatment of other psychiatric and behavioral disorders (e.g., anger, depression, dissociative disorders, eating disorders, guild, and phobias)

## SELECT HEALTH MEDICARE (CMS)

**Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies.** For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

## SELECT HEALTH COMMUNITY CARE (MEDICAID)

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**Summary of Medical Information**
In reviewing the evidence supporting EMDR, the American Psychological Association (APA) found that, like many of the studies of other cognitive behavior and exposure therapies, most of the well-designed EMDR studies have been small, but several meta-analyses have demonstrated efficacy similar to that of other forms of cognitive and behavior therapy. The AAP noted that studies also suggest that the “eye movements are neither necessary nor sufficient to the outcome, but these findings remain controversial.” “Although it appears that efficacy may be related to the components of the technique common to other exposure- based cognitive therapies, as in the previously described cognitive behavior therapies, further study is necessary to clearly identify the effective subcomponents of combined techniques. Follow-up studies are also needed to determine whether observed improvements are maintained over time” (APA, 2004).

Advocates of EMDR therapy state that it is a specialized approach and method that requires supervised training for full therapeutic effectiveness and client safety. Training is considered mandatory for appropriate use. However, a meta-analysis of the literature on EMDR by Davidson and Parker (2001) found that the effectiveness of EMDR was not affected by whether the therapist providing the treatment was trained by the EMDR Institute.

There are insufficient data to support the use of EMDR in the treatment of other psychiatric and behavioral disorders including anger, guilt, phobias, dissociative disorders, eating disorders, and panic and anxiety disorders other than PTSD. In a randomized study on the effectiveness of EMDR treatment





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on negative body image in eating disorder inpatients, Bloomgarden and Calogero (2008) concluded that further research is needed to determine whether EMDR is effective for treating the variety of eating pathology presented by eating disorder inpatients.

In a case series, Schneider et al. (2008) assessed EMDR therapy for patients with chronic phantom limb pain (PLP). A total of 5 subjects with PLP ranging from 1 to 16 years were included in this study. All patients were on extensive medication regimens prior to EMDR therapy; 3 to 15 sessions of EMDR were used to treat the pain and the psychological ramifications. Patients were measured for continued use of medications, pain intensity/frequency, psychological trauma, and depression. Treatment with EMDR resulted in a significant decrease or elimination of PLP, reduction in depression and PTSD symptoms to sub-clinical levels, and significant reduction or elimination of medications related to the PLP and nociceptive pain at long-term follow-up. The authors concluded that the overview and long-term follow-up indicate that EMDR therapy was successful in the treatment of both PLP and the psychological consequences of amputation. The latter include issues of personal loss, grief, self-image, and social adjustment. These results suggest that (i) a significant aspect of PLP is the physiological memory storage of the nociceptive pain sensations experienced at the time of the event, and (ii) these memories can be successfully reprocessed. They stated that further research is needed to explore the theoretical and treatment implications of this information-processing approach.

de Roos et al. (2010) examined if a psychological treatment directed at processing the emotional and somatosensory memories associated with amputation reduces PLP. A total of 10 consecutive participants (6 men and 4 women) with chronic PLP after leg amputation were treated with EMDR. Pain intensity was assessed during a 2-week period before and after treatment (mean number of sessions = 5.9), and at short-term (3 months) and long-term (mean of 2.8 years) follow-up. Multi-variate ANOVA for repeated measures revealed an overall time effect ($F [2, 8] = 6.7$; $p < 0.02$) for pain intensity. Pair-wise comparison showed a significant decrease in mean pain score before and after treatment ($p = 0.00$), which was maintained 3 months later. All but 2 subjects improved and 4 were considered to be completely pain-free at 3 months follow-up. Of the 6 subjects available at long-term follow-up (mean of 2.8 years), 3 were pain-free and 2 had reduced pain intensity. The authors concluded that these preliminary results suggested that, following a psychological intervention focused on trauma or pain-related memories, substantial long-term reduction of chronic PLP can be achieved. However, they stated that larger outcome studies are needed.

In a pilot study, Sandstrom and colleagues (2008) examined the effects of EMDR in women with post-traumatic stress after childbirth. This study consisted of a "before and after" treatment design combined with follow-up measurements 1 to 3 years after EMDR treatment. Quantitative data from questionnaires (Traumatic Event Scale [TES]) were collected. In addition, qualitative data from individual interviews with the participants were collected as well as data from the psychotherapist's treatment notes of the EMDR treatment sessions. A total of 4 women with post-traumatic stress following childbirth (1 pregnant and 3 non-pregnant) were included in this study. All participants reported reduction of post-traumatic stress after treatment. After 1 to 3 years, the beneficial effects of EMDR treatment remained for 3 of the 4 women. Symptoms of intrusive thoughts and avoidance seemed most sensitive for treatment. The authors concluded that EMDR might be a useful tool in the treatment of non-pregnant women severely traumatized by childbirth; however, they stated that further research is needed.

Bae et al. (2008) stated that while CBT is considered to be the first-line of therapy for adolescent depression, there are limited data on whether other psychotherapeutic techniques are also effective in treating adolescents with depression. This report suggested the potential application of EMDR for treatment of depressive disorder related, not to trauma, but to stressful life events. At present, EMDR has only been empirically validated for only trauma-related disorders such as PTSD. These researchers reported the findings of 2 teenagers with major depressive disorder (MDD) who underwent 3 and 7 sessions of EMDR aimed at memories of stressful life events. After treatment, their depressive symptoms decreased to the level of full remission, and the therapeutic gains were maintained after 2 and 3 months of follow-up. The effectiveness of EMDR for depression is explained by the model of adaptive information processing. Given the powerful effects observed within a brief period of time, the authors suggested that further investigation of EMDR for depressive disorders is warranted.

Torun (2010) noted that vaginismus is a type of sexual dysfunction in which spasm of the vaginal musculature prevents penetrative intercourse. The main diagnostic criterion is the presence of recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. In many cases, associated pain or the fear of pain may contribute to its persistence. These researchers reported 2 patients who presented with vaginismus that developed secondary to childhood sexual trauma, which was treated with the EMDR. Randomized controlled trials with PTSD patients and with victims of sexual abuse have shown that EMDR is effective. The standard 8-phase EMDR protocol was used in both of the presented cases. Following 3 sessions of EMDR, the patients exhibited a substantial reduction in self-reported and clinician-rated anxiety, and a reduction in the credibility of dysfunctional beliefs concerning sexual intercourse. The authors concluded that these findings support the notion that EMDR could be an effective treatment alternative for patients with vaginismus of traumatic etiology. These preliminary results need to be validated with well-designed studies.

**Billing/Coding Information**

**CPT CODES**

***Nonspecific CPT codes used to bill for eye movement desensitization and reprocessing include***

| | |
|---|---|
| **90785** | Interactive complexity (List separately in addition to the code for primary procedure) |
| **90832** | Psychotherapy, 30 minutes with patient and/or family member |
| **90833** | Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management services (List separately in addition to the code for primary procedure |
| **90834** | Psychotherapy, 45 minutes with patient and/or family member |
| **90836** | Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (List separately in addition to the code for primary procedure) |
| **90837** | Psychotherapy, 60 minutes with patient and/or family member |
| **90838** | Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure. |
| **90880** | Hypnotherapy |
| **90899** | Unlisted psychiatric service or procedure |

**HCPCS CODES**

| | |
|---|---|
| **H0004** | Behavioral health counseling and therapy, per 15 minutes |

**Not covered for indications listed**

Too numerous to list

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MEDICAL POLICY

# HIPPOTHERAPY (EQUINE MOVEMENT THERAPY OR EQUINE-FACILITATED PSYCHOTHERAPY)

Policy # 252

Implementation Date: 12/30/04

Review Dates: 12/30/05, 2/16/07, 2/21/08, 2/19/09, 2/18/10, 2/17/11, 2/16/12, 10/24/13, 10/23/14, 10/15/15, 10/20/16, 10/19/17, 10/15/18, 10/15/19, 10/15/20, 11/22/21, 9/15/22, 10/16/23, 10/14/24

Revision Dates:

**Disclaimer:**
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

Hippotherapy, also referred to as equine movement therapy, describes rehabilitative therapy using a horse or related mechanical equipment. This type of therapy has been proposed as a technique to decrease the energy requirements and improve walking in patients with cerebral palsy (CP). It is thought that the natural swaying motion of the horse induces a pelvic movement in the rider that simulates human ambulation. In addition, variations in the horse's movements can also prompt natural equilibrium movements in the rider. To attain specific postural responses, the therapist may place the rider in different positions on the horse, such as sitting, side-sitting, prone, or side lying. In many cases, the therapist will ride with the patient in order to facilitate the movement or desired response.

Hippotherapy has been proposed as a form of psychotherapy, sometimes referred to as 'equine-facilitated psychotherapy.' Guidelines or descriptions of how this treatment should be implemented are lacking in relevant literature.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

**Select Health does NOT cover hippotherapy as a rehabilitative or psychological therapy**. This therapy meets the plan's definition of experimental/investigational.

## SELECT HEALTH MEDICARE (CMS)

**Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies.** For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

## SELECT HEALTH COMMUNITY CARE (MEDICAID)

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## Hippotherapy (Equine Movement Therapy or Equine-facilitated Psychotherapy), continued

### Summary of Medical Information

Most of the literature regarding hippotherapy consists of small case series published in the German literature. English language publications also consist of small case series. MacKinnon and colleagues published a small, randomized study of 19 patients that reported no significant effects in most outcome measures. Sterba and colleagues reported on the outcomes of horseback riding in 17 subjects with cerebral palsy. Gross motor function measurements were assessed before and after a once a week horseback riding program for 18 weeks. Gross motor function total scores improved by 7.6% after 18 weeks, returning to baseline 6 weeks after the program ended. This small trial is inadequate to permit scientific conclusions.

Guidelines or descriptions of how this treatment should be implemented are lacking in the literature. No scientific studies examining the benefits of this type of psychotherapy were found. However, in the only three published reports, the authors made claims regarding the therapeutic benefits of equine-facilitated psychotherapy. The reports did not address a specific mental health disorder but praised the activity as an aid to better mental health in general. One such article stated that equine-facilitated psychotherapy is, "… an experiential intervention that offers the opportunity to achieve a gradual awakening to a deeper sense of the self (and the self in relation to others) in a way that effects profound change." Similar claims were made in the other two reports. However, no evidence was supplied to support these claims. Hippotherapy may be provided by a physical therapist, occupational therapist, speech language pathologist (with a certificate of clinical competence), psychologist, or psychotherapist.

### Billing/Coding Information

***Not covered: Investigational/Experimental/Unproven for this indication***

**CPT CODES**

No specific codes identified

**HCPCS CODES**

**S8940** Equestrian/hippotherapy, per session

**Key References**


1. Bertoti DB. Effect of therapeutic horseback riding on posture in children with cerebral palsy. Physical Therapy 1998; 10:1505-12.
2. MacKinnon JR, Hog S. Lariviere J et al. A study of therapeutic effects of horseback riding for children with cerebral palsy. Phys Occup Ther Ped 1995; 15:17-34.
3. McGibbon NH, Andrade CK, Widener G, Cintas HL. Effect of an equine-movement therapy program on gain, energy expenditure, and motor function in children with spastic cerebral palsy: a pilot study. Develop Med Child Neurol 1998; 40:754-62.
4. Sterba JA, Rogers BT, France AP, Vokes DA. Horseback riding in children with cerebral palsy: Effect on gross motor function. Dev Med Child Neurol 2002; 44:301-08.








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## Hippotherapy (Equine Movement Therapy or Equine-facilitated Psychotherapy), continued

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ADMINISTRATION POLICY

# INTERMEDIATE LEVELS OF CARE UTILIZATION IN BEHAVIORAL HEALTH

Policy # 582
Implementation Date: 1/19/17
Review Dates: 12/21/17, 12/13/18, 12/18/19, 12/17/20, 11/22/21, 11/9/22, 12/21/23, 12/17/24
Revision Dates: 4/9/20, 12/30/20, 5/6/22, 3/27/24

**Disclaimer:**
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2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

Intermediate levels of care define services to assist patients with behavioral health issues that lies between outpatient/clinic/office-based services to in-patient service. These services include:

Acute Inpatient: The highest intensity of medical and nursing services provided within a structured environment providing 24-hour skilled nursing and medical care. Full and immediate access to ancillary medical care must be available for those programs not housed within general medical centers.

Partial Hospital: An intensive non-residential level of service, where multidisciplinary medical and nursing services are required. This care is provided in a structured setting, similar in intensity to an inpatient setting, meeting for more than four hours (and, generally, less than eight hours) daily.

Residential Treatment: Care provided as a sub-acute level with skilled nursing care. These services can be provided in intermediate care facilities (IFCs) or have other licensing designations that may vary by state.

Crisis Residential Treatment: This is a non-medical, supervised, structured living arrangement for patients in a partial hospital program. The residential program is used for short-term, crisis stabilization, and provides supervised overnight care in a non-medical setting.

Intensive Outpatient: Multidisciplinary, structured services provided at a greater frequency and intensity than routine outpatient treatment. These are generally up to four hours per day, up to five days per week. Common treatment modalities include individual, family, and group psychotherapy, and medication management.

Outpatient: The least intense level of service, provided in an office setting. Individual psychotherapy sessions occur for up to 60 minutes per day and group psychotherapy sessions for up to 90 minutes per day.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

**Select Health covers intermediate levels of care utilization for behavioral health services** *in limited circumstances* when criteria are met.

**A. General Criteria for Coverage of Intermediate Levels of Care:**

1. Submitted documentation demonstrates medical necessity as defined in InterQual
2. Documentation does not indicate member's clinical circumstance would benefit from higher levels of care





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## Intermediate Levels of Care Utilization in Behavioral Health, continued

**B. Specific Criteria for Different Types of Intermediate Care:**

1. Partial Hospitalization Psychiatric Care (Adult, Child/Adolescent):

   **a) Medical Necessity** (***Both*** are required to consider for admission)
   - The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional
   - Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition V (DSM-V)

   **b) Admission Criteria** (***All*** criteria must be met to recommend admission)
   - The patient's mental condition requires skilled medical and nursing observation (e.g., serial mental status checks, medication administration, monitoring of vital signs) and is likely to improve with this intervention
   - Clinical documentation clearly indicates that the patient could not be treated safely at a lower level of care or that partial hospitalization could safely substitute for acute inpatient care
   - The patient's psychosocial supports are such that the patient can be supervised and maintained without clinical supervision for that period of time outside the program
   - The patient's condition requires multidisciplinary intervention for four (or more) hours daily and more than three days per week

   **c) Continuing Care Criteria** (***All*** criteria must be met to recommend continuing care)
   - Despite adequate treatment, the patient continues to exhibit signs and symptoms that led to the admission, or new problems have emerged that themselves meet the criteria for PHP admission
   - The patient's problems must be clearly documented in the medical record, and there must be a progress note by the provider for each day of treatment
   - There must be clear clinical documentation that transition of the patient to a lower level of care would result in exacerbation or re-emergence of symptoms sufficient to meet PHP admission criteria

2. Intensive Outpatient Therapy Psychiatric Care (Adult, Child/Adolescent):

   **a) Medical Necessity** (***Both*** are required to consider for treatment)
   - The patient must have been diagnosed with a psychiatric disorder by a licensed mental health professional
   - Symptoms of this illness must accord with those described in the Diagnostic and Statistical Manual of Mental Disorders, Edition V (DSM-V)

   **b) Admission Criteria** (***All*** criteria must be met to recommend treatment)
   - There is documentation of significant and acute deterioration in social, occupational, educational, or family functioning
   - The proposed treatment plan addresses the signs and symptoms consistent with the observed deterioration in functioning
   - The patient's condition will benefit from the proposed intervention

   **c) Continuing Care Criteria** (***All*** criteria must be met to recommend continuing care)
   - The patient continues to exhibit signs and symptoms consistent with admission criteria
   - The treatment plan reflects ongoing interventions to alleviate these impairments
   - Clinical documentation supports that attempts to transition to a lower level of care would likely result in decompensation or exacerbation of the illness

Note: Boarding is not covered for any outpatient services.





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## Intermediate Levels of Care Utilization in Behavioral Health, continued

### SELECT HEALTH MEDICARE (CMS)

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### SELECT HEALTH COMMUNITY CARE (MEDICAID)

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**Summary of Medical Information**

Intermediate care services consist of partial hospitalization/day treatment programs (PHP), intensive outpatient programs (IOP), adult intensive services (AIS), and child and family intensive services (CFIT). They provide both transitional and standalone treatment for patients meeting medical necessity criteria for the level of care. Intermediate care services provide substantial clinical support for patients who are either in transition from a higher level of care or at risk for admission to a higher level of care.

Select Health is committed to the philosophy of providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual patient's biopsychosocial needs. Published evidence demonstrates the continuum of care for behavioral health disorders is a fluid treatment pathway, where patients may enter treatment at any level and be moved to more or less-intensive settings or levels of care as their changing clinical needs dictate. At any level of care, such treatment is individualized, active, and takes into consideration the patient's stage of readiness to change/readiness to participate in treatment.

**Billing/Coding Information**

**CPT CODES**

| | |
|---|---|
| **3085F** | Suicide risk assessed (MDD, MDD ADOL) |
| **90791** | Psychiatric diagnostic evaluation |
| **90792** | Psychiatric diagnostic evaluation with medical services |
| **90832** | Psychotherapy, 30 minutes with patient and/or family member |
| **90833** | Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service |
| **90834** | Psychotherapy, 45 minutes with patient and/or family member |
| **90836** | Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service |
| **90837** | Psychotherapy, 60 minutes with patient and/or family member |
| **90838** | Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service |
| **90839** | Psychotherapy for crisis; first 60 minutes |
| **90840** | Psychotherapy for crisis; each additional 30 minutes |
| **90845** | Psychoanalysis |
| **90846** | Family psychotherapy (without the patient present) |





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## Intermediate Levels of Care Utilization in Behavioral Health, continued

| | |
|---|---|
| **90847** | Family psychotherapy (conjoint psychotherapy) (with patient present) |
| **90849** | Multiple-family group psychotherapy |
| **90853** | Group psychotherapy (other than of a multiple-family group) |
| **90863** | Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure) |
| **90899** | Unlisted psychiatric service or procedure |
| **96152** | Health and behavior intervention, each 15 minutes, face-to-face; individual |
| **96153** | Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients) |
| **96154** | Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present) |
| **96155** | Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present) |

**HCPCS CODES**

| | |
|---|---|
| **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 |
| **S3005** | Performance measurement, evaluation of patient self-assessment, depression |
| **T2048** | Behavioral health; long-term care residential (nonacute care in a residential treatment program where stay is typically longer than 30 days), with room and board, per diem |

**Key References**

1. American Society of Addiction Medicine, Inc. Patient Placement Criteria for the Treatment or Substance Related Disorders, Third edition. Maryland: American Society of Addiction Medicine.
2. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-V) American Psychiatric Association.
3. Federal Register Vol.78 No. 219/Wednesday, November 13, 2013 / Rules and Regulations.
4. SAMHSA – Treatment of Substance Use Disorders.

### Revision History

| Revision Date | Summary of Changes |
|---|---|
| 3/17/24 | For Commercial Plan Policy, added the following note to provide clarification: “Boarding is not covered for any outpatient services.” |







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## Intermediate Levels of Care Utilization in Behavioral Health, continued

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MEDICAL POLICY

# MICKEL THERAPY FOR THE TREATMENT OF FIBROMYALGIA

Policy # 402

Implementation Date:5/19/08

Review Dates: 6/11/09, 6/17/10, 9/15/11, 11/29/12, 12/19/13, 12/18/14, 12/10/15, 12/15/16, 12/21/17, 12/2/18, 12/11/19, 12/9/20, 10/29/21, 11/16/22, 12/16/23, 12/17/24

Revision Dates:

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## Description

Fibromyalgia is a common cause of chronic musculoskeletal pain. It is one of a group of soft tissue pain disorders that affect muscles and soft tissues such as tendons and ligaments. None of these conditions is associated with tissue inflammation and the etiology of the pain is not known. Fibromyalgia is 6 times more common in females. The prevalence of this disorder in the community increases with age from 2% at age 20 to 8% at age 70; most patients present between the ages of 30 and 55. In approximately one-half of cases, the symptoms appeared to begin after a specific event, most often some form of physical or emotional trauma, or a flu-like illness.

Mickel Therapy (Mickel Health Initiatives Limited, Edinburgh, Scotland) is a "wellness" approach to healthcare developed by Dr. David Mickel. Mickel Therapy requires no medication, supplements, dietary change, or hands-on modalities. The therapy is completely spoken and consists of one-to-one private one-hour sessions at 1−3-week intervals. The Mickel Therapy Practitioner guides the client through the treatment process by providing an accurate understanding of how the body works in health; redefining the nature of symptoms and disease; describing factors that resulted in the onset of symptoms; explaining factors that allow symptoms to persist; provide all the relevant knowledge, skills, and techniques that will lead to the complete cessation of symptoms when implemented effectively; and provide support and guidance during implementation of program principles and practices.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

**Select Health does NOT cover Mickel Therapy for the treatment of fibromyalgia.** It has no demonstrated clinical utility beyond current use in behavioral health services; this meets the plan's definition of experimental/investigational.

## SELECT HEALTH MEDICARE (CMS)

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## Mickel Therapy for Treatment of Fibromyalgia, continued

### SELECT HEALTH COMMUNITY CARE (MEDICAID)

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**Summary of Medical Information**

There is no evidence that tissue inflammation is present in patients with fibromyalgia. Thus, it is not surprising that anti-inflammatory medications are not an effective form of treatment. Other analgesics, such as acetaminophen and tramadol, alone or in combination, may be helpful. They are generally used in combination with CNS active medications, such as tricyclic antidepressants, SSRIs, SNRIs, and the skeletal muscle relaxant cyclobenzaprine, when the latter are not effective alone. Other agents that may be effective, include the muscle relaxant carisoprodol and the sedative sodium oxybate. A number of investigative approaches have investigated use of antiviral and immune modulating agents, such as acyclovir and immune globulin, hormonal manipulation with human growth hormone, nutritional supplementation with 5-hydroxytryptophan, antagonist of the serotonin 5-HT3 receptor (tropisetron), and pramipexole, a dopamine agonist.

Non-medicinal treatments that have been evaluated in controlled studies include cardiovascular fitness training, muscle strengthening, physical therapy, EMG (electromyogram) biofeedback, hypnotherapy, and cognitive behavioral therapy. A 2004 systematic review found strong evidence for effectiveness of cardiovascular exercise, cognitive behavioral therapy (CBT), patient education, and multidisciplinary interventions that combine elements of aerobic exercise, CBT, and patient education. The same review found moderate evidence for efficacy of strength training, hypnotherapy, biofeedback, and mineral springs, or salt baths (balneotherapy). Weak evidence exists for manipulative and manual therapies (chiropractic, massage), and physical modalities, including electrotherapy and therapeutic ultrasound. While moderate evidence was also found for acupuncture, a subsequent well-designed, randomized and sham-controlled trial, did not find any advantage of traditional Chinese acupuncture over a variety of sham procedures.

**Billing/Coding Information**

**CPT CODES**

***Not covered: Investigational/Experimental/Unproven for this indication***

| | |
|---|---|
| **96150** | Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment |
| **96151** | Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment |
| **96152** | Health and behavior intervention, each 15 minutes, face-to-face; individual |
| **96154** | Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present) |

**HCPCS CODES**

No specific codes identified

**Key References**

1. Goldenberg DL. Clinical manifestations and diagnosis of fibromyalgia in adults. 2008. UpToDate. Available: http://www.utdol.com/utd/content/topic.do?topicKey=painrheu/2921&selectedTitle=2~118&source=search_result. Date Accessed: March 10, 2008.
2. Goldenberg DL. Treatment of fibromyalgia in adults. 2008. UpToDate. Available: http://www.utdol.com/utd/content/topic.do?topicKey=painrheu/4625&selectedTitle=1~118&source=search_result. Date Accessed: March 10, 2008.





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## Mickel Therapy for Treatment of Fibromyalgia, continued

3. https://ard.bmj.com/content/76/2/318.full
4. http://rheum.ca/wp-content/uploads/2017/11/2012CanadianFMGuidelines_17August2012.pdf
5. Macfarlane, G.J., Kronisch, C., Dean, L.E., Atzeni, F., Hauser, W., Flub, E., … Jones, G.T. (2017). EULAR revised recommendations for the management of fibromyalgia. *Ann Rheum Dis*, 76:318–328. doi: 10.1136/annrheumdis-2016-209724
6. Mickel Health Initiatives Ltd. Welcome to Mickel Therapy. 2008. Available: http://www.mickeltherapy.com/information.html. Date Accessed: March 11, 2008.

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Select Health

MEDICAL POLICY

# TRANSCRANIAL MAGNETIC STIMULATION FOR PSYCHIATRIC DISORDERS AND NAVIGATIONAL TOOL FOR NEUROSURGERY

Policy # 241
Implementation Date:3/1/04
Review Dates: 1/13/05, 1/26/06, 2/15/07, 2/21/08, 8/19/10, 9/15/11, 10/24/13, 10/23/14, 10/15/15, 10/20/16, 10/15/18, 10/15/19, 1/8/21/ 11/22/21, 9/15/22, 12/27/23, 12/27/24
Revision Dates: 7/13/09, 11/29/12, 10/1/17, 11/2/17, 7/3/19, 9/27/19, 1/15/21, 6/8/22, 11/7/22, 2/27/24 7/8/24, 7/17/24, 3/10/25, 6/12/25



## Description

*Psychiatric Disorders:* Major depressive disorder (MDD) affects 2%–4% of overall individuals, 5%–10% of primary care patients, and 10%–14% of medical inpatients. A variety of behavioral and pharmacological strategies are employed as first-line treatment of depression. These include exercise/resumption of activities stopped due to depression, psychotherapy, and antidepressant medication. However, only 40% of patients in primary care respond to the first choice of antidepressant medication, which often prompts augmentation with another medication. Various studies have suggested that ~25% of depressed patients have treatment resistant depression defined as a failure of 2 or more antidepressant therapies.

Treatment-resistant depression is defined as patients who fail to respond to 3 or more antidepressant medications. The current standard treatment for these patients is electroconvulsive therapy (ECT). ECT requires general anesthesia and has prominent cognitive clouding for a period after the procedure. Transcranial magnetic stimulation (TMS), which is also called unilateral or bilateral repetitive transcranial magnetic stimulation, has been studied as an alternative treatment for patients with treatment-resistant depression. In contrast to electroconvulsive therapy, TMS does not require anesthesia or analgesia. It works by penetrating the skull with an electromagnetic field to stimulate cortical neurons in the prefrontal cortex and more distal neurological pathways.

TMS has been FDA approved for the treatment of major depressive disorder in adult patients who have failed to achieve satisfactory improvement from one prior antidepressant medication at or above the minimal effective dose and duration in the current episode. This procedure is usually carried out in an outpatient setting. TMS can be applied once or repeated many times per second with variation in intensity, site, and orientation of the magnetic field. The positioning of the coil and administration of the pulse sequence itself may be done by a trained technician. Current studies have evaluated use of TMS from 10–30 sessions, typically lasting ~15 minutes.

*Navigational Tool for Neurosurgery:* Navigated transcranial magnetic stimulation (nTMS) is a non-invasive functional mapping technique that utilizes magnetic stimulation to generate electrical current in the cerebral cortex. Motor cortex mapping is conducted by stimulating different regions of the brain and measuring the modulatory effect via surface electrodes placed over desired muscles. Alternatively, in language and speech mapping, the patient names objects displayed every few seconds on a computer monitor during magnetic stimulation. The surgeon uses the nTMS mapping results pre-surgically for treatment planning and intraoperatively, in conjunction with direct cortical stimulation, for surgical guidance.





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## Transcranial Magnetic Stimulation for Psychiatric Disorders and Navigational Tool for Neurosurgery, continued

**COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)**

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

**I. TMS for Psychiatric Disorders**

**Select Health covers unilateral or bilateral repetitive transcranial magnetic stimulation (TMS)** in patients with treatment-resistant depression when either A or B are met:

A. TMS will be approved if recommended by Intermountain Health Psychiatry Group; or

B. For all other clinicians, the following criteria must be met:

Criteria for Coverage (Must Meet ALL):

1. Patient is ≥ 18 years of age; and

2. Diagnosis of major depressive disorder (MDD) by a licensed mental health professional (Psychiatrist or Psychiatric Advanced Practice Registered Nurse) that meets the DSM-5 definition of major depressive disorder; and

3. TMS must be recommended by a Psychiatrist or Psychiatric Advanced Practice Registered Nurse, who has examined the patient face-to-face and reviewed the record, and monitored by a physician/APP (advanced practice provider) to evaluate for neurological complications that may require immediate intervention; the physician/APP is responsible for determining motor threshold for the TMS and response to therapy; and

4. Failure of medication therapy (either 4A or 4B), defined by:

   A. New onset/non-recurrent depression: defined as moderate-to-severe depression with initial diagnosis within the past 24 months

      i. Documented failure, and prescribed by treating Physician, Advanced Practice Registered Nurse, or Certified Physician Assistant, of at least 4 antidepressant courses of maximally tolerated dosage and duration (>4 weeks), from at least 2 different agent classes within the past 24 months of the current, moderate-to-severe episode of depression (as defined by a validated scale*); or

      ii. Demonstrated intolerance to at least 4 different courses of psychopharmacologic medications from at least 2 different agent classes, as defined by intolerable side effects that are not expected to diminish or resolve with continued administration of the medication. within the past 24 months of the current, moderate-to-severe episode of depression (as defined by a validated scale*)

      **OR**

   B. Chronic/recurrent depressive disorder: defined as chronic moderate-to-severe depression or recurrent acute episodes treated for 24 months or greater

      i. Documented failure, and prescribed by treating Physician, Advanced Practice Registered Nurse, or Certified Physician Assistant, of at least 2 antidepressant courses of maximally tolerated dosage and duration (>4 weeks), from at least 2 different agent classes within the past 12 months of the current, moderate-to-severe episode of depression (as defined by a validated scale*); or

      ii. Demonstrated intolerance to at least 2 different courses of psychopharmacologic

medications from at least 2 different agent classes, as defined by intolerable side effects that are not expected to diminish or resolve with continued administration of the medication. within the past 12 months of the current, moderate-to-severe episode of depression (as defined by a validated scale*); and

5. A trial of evidence-based psychotherapy for depression was attempted of an adequate frequency and duration without documented significant improvement in depressive symptoms. An adequate trial of evidence-based psychotherapy is typically comprised of at least 15 sessions over a 4- to 6-month period.

6. TMS Treatment: 36 treatments over a 10-week period, which would include both initial and tapering of TMS.

7. For potential retreatment, the member must meet *all* the criteria below:

    1. The member meets initiation criteria above; *and*
    2. The member has relapsed following TMS despite other treatment approaches (e.g., psychotherapy, pharmacotherapy), as appropriate; *and*
    3. The member had previously had at least a 50% reduction in depressive symptoms with TMS, as documented by standardized rating scales that reliably measure depressive symptoms *(e.g., Beck Depression Scale [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], PHQ-9, OQ-45.2, OQ-30, etc.), and this improvement was maintained for at least two months after the prior TMS treatment course; repeat TMS treatment within 60 days following the termination of the prior TMS course is considered not medically necessary

8. TMS is considered contraindicated in the below circumstances:

    - Members with substance abuse in past 90 days, and/or with known substance abuse potential; or
    - The member has high suicide risk requiring hospitalization; or
    - The member has a metal implant in or around the head (e.g., aneurysm coil or clip, metal plate, ocular implant, stent); or
    - The member has a neurological condition(s) (e.g., cerebrovascular disease, dementia, history of repetitive or severe head trauma, increased intracranial pressure or primary or secondary tumors in the central nervous system); or
    - Presence of an implanted magnetic-sensitive medical device located less than or equal to 30 cm from the TMS magnetic coil or other implanted metal items including, but not limited to a cochlear implant, implanted cardiac defibrillator (ICD), pacemaker, vagal nerve stimulator (VNS), or metal aneurysm clips or coils, staples or stents. (Dental amalgam fillings are not affected by the magnetic field and are acceptable for use with TMS); or
    - Members with severe cardiovascular disease, unless they have been evaluated and cleared for TMS treatment by a cardiologist.

9. Motor Threshold Determination

Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management, is considered reasonable and necessary when there is a change in clinical status or medical regimen that is expected to alter cortical excitability. The medical record must clearly document the rationale for the performance of a motor threshold re-determination. Routine performance of motor threshold re-determination during rTMS therapy will be considered not reasonable and necessary.

**More than three motor threshold re-determinations in a rolling six-month period will be denied.** Denied claims may be appealed with supporting documentation addressing the medical necessity (e.g., when there is a change in clinical status or medical regimen that is expected to alter cortical excitability or there is a demonstrated need for an episode of retreatment). The medical record must clearly document the rationale for the motor threshold re-determination.

## Transcranial Magnetic Stimulation for Psychiatric Disorders and Navigational Tool for Neurosurgery, continued

**Select Health does NOT cover unilateral repetitive TMS** for any other behavioral health indication besides MDD as itis considered experimental/investigational.

**Select Health does NOT cover bilateral repetitive TMS** for any other behavioral health condition besides MDD as it is unproven.

**Select Health does not cover TMS for migraine headaches (e.g., SpringTMS)**; further high-quality studies are needed to standardize protocols and clarify long-term efficacy. Therefore, this meets the plan's definition of experimental/investigational.

**Select Health does NOT cover TMS** as maintenance therapy to prevent relapse.

**Select Health does NOT cover TMS for ages 17 and under;** this therapy is considered experimental/investigational for this age group.

**II. nTMS for Neurosurgery**

**A. Select Health covers nTMS when the following criteria are met:**

1. nTMS for motor mapping:
    a. Age > 1 year (equipment limitations such as stimulator size would make implementation at younger ages problematic).

**OR**

2. nTMS for language mapping:
    a. Age > 12 years (assuming normal neurodevelopmental status)

**AND**

3. If the patient is a child, nTMS is only covered for the following conditions, and when the age requirements are met, and meets one of the following (either a or b):

a. A supratentorial tumor that is being targeted for resection and may encroach on cortical motor or language pathways; or

b. Drug-resistant epilepsy, when detailed motor/language mapping is required as part of a presurgical evaluation at a National Association of Epilepsy Centers (NAEC) Level 4-certified comprehensive epilepsy program.

Note: Surgical intervention would include procedures with either curative (as with targeted resection of seizure-generating brain tissue) or palliative (as with implanted neuromodulation devices: DBS, RNS) intent.

4. *Contraindications:* No absolute contraindications currently exist. Rare clinical scenarios in which nTMS is requested in the context of existing cranial/intracranial may be reviewed on a case-by-case basis.

## SELECT HEALTH MEDICARE (CMS)

**Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies.** For the most up-to-date Medicare policies and coverage, please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website





Select Health

## Transcranial Magnetic Stimulation for Psychiatric Disorders and Navigational Tool for Neurosurgery, continued

### SELECT HEALTH COMMUNITY CARE (MEDICAID)

**Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used.** For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

**Summary of Medical Information**

*Psychiatric Disorders:* A review of the literature in 2017 identified 12 systematic reviews and 36 primary studies which were identified that met inclusion criteria. A total of 2,829 patients were involved in the 36 primary studies published between 2006 and 2016, ranging from the smallest study of 7 patients to the largest study of 301 patients.

All but one of the studies focused on patients with treatment resistant depression. The study did not focus solely on depression but also included depressed patients with bipolar disease (Fitzgerald et al., 2016). No studies were identified for any of the other conditions for which TMS has been suggested to have benefit.

The systematic reviews were all dated from 2013 to 2016 and supported unilateral repetitive transcranial magnetic stimulation (rTMS) as an effective treatment option for treating resistant depression, though, several noted rTMS was not as effective as ECT in treating this population (Berlim et al., 2013, Health Quality, 2016, and Ren et al., 2014). Several of these reviews tended to note the: "… low quality of the evidence …" in the systematic reviews analyzed and found bilateral rTMS to be no more effective than unilateral rTMS. None of the systematic reviews commented on any outcomes related to deep TMS.

Four of the primary studies compared efficacy and safety of rTMS to ECT and confirmed rTMS to be less effective than ECT in relieving MDD and probably less durable. These studies also suggest safety concerns, especially around cognitive impairment; they are equivalent in the long-term for the two therapies, though, rTMS may have some short-term benefit on cognitive side effects.

Only 3 of the primary studies assessed deep transcranial magnetic stimulation (dTMS) (Levkovitz et al., 2011 and 2015, and Rapinesi et al., 2015). None of these studies were comparative to rTMS and the Rapinesi study focused on maintenance therapy. These studies support efficacy and safety of dTMS in treating MDD but comparative effectiveness to rTMS cannot be determined. Maintenance therapy is another area in which questions remain. Only the Rapinesi study from 2015 looked at maintenance therapy and this was related to dTMS therapy.

Similarly, literature on low frequency versus high frequency TMS is limited, with a few of the studies noting this method, but primarily, in the context of bilateral therapy rTMS to the left frontal cortex and low frequency TMS to right frontal cortex. The systematic review by Berlim et al. in 2013, suggests low frequency TMS to have equal benefits to high frequency TMS, though, it concluded this therapy to be "promising."

In conclusion, current published literature is of moderate volume and quality. It supports efficacy and safety of rTMS in treating treatment resistant depression, though, it would appear to be not as effective as ECT. Though safety of TMS is high and often spoken of as a reason for using TMS over ECT, published studies do not support a significant safety benefit of TMS over ECT, particularly in the long-term. Questions remain in the literature related to the need, timing, frequency, and duration of any maintenance therapy. Additionally, bilateral rTMS does not appear to offer any benefit over standard left frontal cortex rTMS.

*Navigational Tool for Neurosurgery:* Navigated Transcranial Magnetic Stimulation (nTMS) is an outpatient-based, noninvasive modality used in high-resolution mapping of cortical function (both motor and language). It superimposes virtual "pins" on areas of critical cortical function using 3D MRI reconstructions and a commercial navigated TMS device (Nextstim NBS system). It allows the patient to rest comfortably in a padded recliner during the course of an outpatient visit. Additionally, the ease-of-use with nTMS allows for age ranges spanning infancy to adults to undergo the procedure with minimal discomfort.

## Transcranial Magnetic Stimulation for Psychiatric Disorders and Navigational Tool for Neurosurgery, continued

nTMS is distinct from other existing approaches/modalities such as: 1) Direct Cortical Stimulation (DCS) via mono or bipolar electrical stimulation in the operating room, 2) extraoperative, inpatient-based electrical DCS via implanted EEG electrodes, and 3) outpatient MRI-based examinations that occur in technically-demanding (and age-restrictive) environments, as with Magnetoencephalography/Magnetic Source Imaging and functional MRI.

The defining mechanism of nTMS is magnetic induction of an underlying cortical potential, resulting in activation (or occasionally inhibition) of cortical function zones. The physical underpinnings of TMS in motor mapping are linked closely to widely used Transcranial Motor Evoked Potentials (TcMEPs) via electrical stimulation, however, with magnetic stimulation, overlying pain fibers in skin and scalp are not activated, resulting in significantly less patient discomfort and need for sedation/analgesia. Additionally, the resolution of nTMS is comparable to data generated via electrical DCS performed in the operating room. These features allow for acquisition of high-value data to occur outside the technically complex environments of the OR, MRI suite, or MEG/MSI scanner while accommodating a broader range of ages and developmental levels.

Navigated TMS is used in cortical mapping for both motor and language control. Motor potentials are more readily induced with nTMS due to the early maturation of motor pathways as well as the passive nature of testing (i.e., nTMS can typically be obtained in the comfort of a reclining chair as a child, adolescent, or adult can be distracted with an iPad). Language is more technically challenging due to the requirement of sustained attention and active participation throughout the course of testing but can still be successfully performed in adolescents and beyond.

As TMS (in some form) has been implemented safely for several years, there are no specific instances in which its use is contraindicated. However, concerns may arise if cranial/intracranial hardware already is in place (as with cochlear implants, DBS, and RNS devices). These specific circumstances would likely be exceedingly rare in clinical practice.

**Billing/Coding Information**

**CPT CODES**

***Covered for the indications listed above when criteria are met***

| | |
|---|---|
| **90867** | Therapeutic repetitive transcranial magnetic stimulation treatment planning |
| **90868** | ; delivery and management, per session |
| **90869** | ; subsequent motor threshold re-determination with delivery and management |

**HCPCS CODES**

No specific codes identified

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## Transcranial Magnetic Stimulation for Psychiatric Disorders and Navigational Tool for Neurosurgery, continued


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MEDICAL POLICY

# ULTRA RAPID OPIOID DETOXIFICATION (UROD)

Policy # 348
Implementation Date:4/5/06
Review Dates: 5/17/07, 4/24/08, 4/23/09, 2/18/10, 4/21/11, 4/12/12, 6/20/13, 4/17/14, 5/7/15, 4/14/16, 4/27/17, 7/16/18, 4/18/19, 4/15/20, 4/15/21, 2/22/22, 4/24/23, 4/12/24, 4/17/25
Revision Dates:

**Disclaimer:**
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

Detoxification, although important, is only the first step in long-term relapse prevention treatment of opiate addiction. Proven detoxification procedures presently involve a gradual withdrawal followed by medication and long-term psychosocial support in producing long-term abstinence from use associated with opioid use disorder. Detoxification is associated with acute symptoms followed by a longer period of protracted symptoms (i.e., 6 months) of withdrawal. Although typically not life threatening, acute detoxification symptoms include irritability, anxiety, apprehension, muscular and abdominal pains, chills, nausea, diarrhea, yawning, lacrimation, sweating, sneezing, rhinorrhea, general weakness, and insomnia. Protracted withdrawal symptoms include a general feeling of reduced well-being and drug craving; relapse is common during this period.

Dissatisfaction with current approaches to detoxification has led to interest in using relatively high doses of opioid antagonists, such as naltrexone, naloxone, or nalmefene under deep sedation with benzodiazepine or general anesthesia. This strategy has been referred to as "rapid," "ultra-rapid," "anesthesia-assisted," or "one-day" detoxification (UROD). In the UROD procedure, opiate detoxification is induced using a bolus injection of very high doses of an opiate antagonist (naloxone) under general anesthesia or heavy sedation followed by a slow infusion of low dose naloxone. The 4-hour procedure is carried out in an ICU and the patient requires 1−2 days of hospitalization for a full treatment protocol. The use of opioid antagonists accelerates the acute phase of detoxification, which can be completed within 24−48 hours. Since the patient is under anesthesia, there is no patient discomfort or memory of the symptoms of acute withdrawal, although protracted symptoms of withdrawal may still be present post-anesthesia. Various other drugs are also administered to control acute withdrawal symptoms, such as clonidine (to attenuate sympathetic and hemodynamic effects of withdrawal), odensetron (to control nausea and vomiting), and somatostatin (to control diarrhea). Hospital admission is required if general anesthesia is used. If heavy sedation is used, the program can potentially be offered on an outpatient basis. Initial detoxification is then followed by ongoing support for the protracted symptoms of withdrawal. In addition, naltrexone may be continued to discourage relapses.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

**Select Health does NOT cover ultra-rapid detoxification for the treatment of opioid dependence**. This meets the plan's definition of experimental/investigational.

## SELECT HEALTH MEDICARE (CMS)

**Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, and InterQual criteria are not available, the Select Health Commercial policy applies.** For the most up-to-date Medicare policies and coverage,





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## Ultra Rapid Opioid Detoxification (UROD), continued

please visit their search website http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?from2=search1.asp& or the manual website

## SELECT HEALTH COMMUNITY CARE (MEDICAID)

**Select Health Community Care policies typically align with State of Utah Medicaid policy, including use of InterQual. There may be situations where NCD/LCD criteria or Select Health commercial policies are used.** For the most up-to-date Medicaid policies and coverage, please visit their website http://health.utah.gov/medicaid/manuals/directory.php or the Utah Medicaid code Look-Up tool

### Summary of Medical Information

The major safety considerations regarding ultra-rapid detoxification are the risks associated with general anesthesia in combination with opioid antagonists. While patients are generally intubated and ventilated, eliminating the risk of choking, intravenous naloxone has been associated with cardiovascular complications such as cardiac arrest and pulmonary edema. These potential safety issues are particularly important, since opioid withdrawal itself is not associated with life-threatening complications. In contrast, advocates of ultra-rapid detoxification point out that detoxification is a painful procedure, and that the risk of anesthesia has generally been considered acceptable when used to relieve pain.

The initial search of the published medical literature did not identify any controlled studies that directly compared the outcomes of ultra-rapid detoxification with other methods of detoxification. As also noted by two published reviews, most of the published literature consists of single institution case series, including a variety of patient populations, a variety of protocols, varying in the opioid antagonist used, the dose and mode of administration, the anesthetic agent, duration of anesthesia, and adjunct medications used. Two randomized trials were identified; however, these studies focused on treatment regimens that varied only in the level of sedation used and did not include a conventionally treated control group.

Regarding severity and duration of withdrawal symptoms, a review conducted by Gowing et al. for the Cochrane Library suggests that most patients did experience moderate withdrawal symptoms lasting a few days post-anesthesia or sedation, including nausea, vomiting, diarrhea, and sleep disturbances. In addition, withdrawal severity may also be related to the anesthetic used. However, without a controlled trial, no conclusion can be made regarding the duration or severity of withdrawal symptoms compared to other techniques of detoxification.

Most of the studies did not report short- or long-term follow-up of abstinence. Moreover, those studies that did include follow-up reported conflicting results. For example, Seoane et al. reported that 279 of the 300 patients treated were abstinent after 1 month, while in Cucchia's study of 20 patients, 16 reported some resumption of heroin in the 6 months following detoxification, with 60% considered to have relapsed. Albanese assessed the relapse at 6 months in 120 patients. Relapse data were available for 111 patients; 55% were relapse-free. Again, without controlled studies in similar populations of patients, no conclusions can be drawn about the relative long-term efficacy of ultra-rapid detoxification compared with other treatment strategies.

A variety of adverse events have been reported in small numbers of patients, including vomiting while under anesthesia or sedation, various cardiac rhythm disturbances, pulmonary dysfunction, and renal insufficiency. Vomiting under sedation is particularly worrisome due to the threat of aspiration. Techniques reported to minimize this risk include intubation, use of prophylactic antibiotics, and the use of medication to diminish the volume of gastric secretions. Several deaths occurring either during anesthesia or immediately afterward have been reported. Also, deaths after ultra-rapid detoxification have been reported. Of particular concern, is the fact that the use of opioid antagonists results in loss of tolerance to opioids, rendering the patient susceptible to overdose if the patient returns to his/her pre-detoxification dosage of drugs.

In 2000, the American Society of Addiction Medicine published a public policy statement regarding opiate detoxification under sedation or anesthesia. This policy statement enumerated several positions, with the following two being the most relevant to this discussion:





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## Ultra Rapid Opioid Detoxification (UROD), continued

1. Opioid antagonist agent detoxification under sedation or anesthesia (OADUSA) can be an appropriate withdrawal management intervention for selected patients, provided that such services are performed by adequately trained staff with access to appropriate emergency medical equipment.
2. Although there is medical literature describing various techniques of OADUSA, more research is needed to better define its role in opioid detoxification. Further studies of outcomes are needed, including both the safety and efficacy of OADUSA as compared to other opioid detoxification modalities, as well as any differential effects on the long-term rehabilitation of opioid addicts.

An updated search of the literature through September 2005 returned two new randomized clinical trials. Both studies found that rapid detoxification with general anesthesia did not improve treatment retention, overall recidivism, or significantly improve severity of withdrawal symptoms compared to standard detoxification procedures without general anesthesia.

De Jong et al. randomized 272 opioid-dependent patients attending methadone clinics to rapid detoxification without anesthesia (RD) or rapid detoxification with general anesthesia (RD-GA). All patients were treated for seven days at an addiction treatment center. The patients randomized to RD-GA received four hours of general anesthesia and the opioid antagonist. They were monitored for another four hours and discharged back to the treatment center. Opioid abstinence was monitored in both groups with urinalysis and the intensity of the signs and symptoms of withdrawal during and after treatment was assessed in both groups using subjective and objective measures. One month following rapid detoxification, 62.8% of the RD-GA patients and 60.0% of the RD group were abstinent from opioids (p=0.71). No adverse events or complications occurred during RD; however, in the RD-GA group five serious adverse events occurred, necessitating hospital admission. According to subjective reports the RD-GA group experienced more craving and withdrawal distress. However, the differences were not significant at one week. The authors also conducted a cost analysis and found that the cost of treatment with general anesthesia was much higher than RD without anesthesia. Because both treatments showed an equivalent efficacy in this study, the authors concluded that rapid detoxification without general anesthesia is the more cost-effective treatment.

Collins et al. randomized heroin-addicted patients to three study arms: rapid detoxification with general anesthesia, buprenorphine followed by naltrexone induction beginning on day 2, or clonidine plus a variety of supportive medications for one week, followed by naltrexone induction beginning day 7. Following discharge, all patients were treated with naltrexone for 12 weeks and relapse-prevention psychotherapy. Treatment retention at 12 weeks did not differ significantly across the three groups (20% RD-GA group, 24% buprenorphine group, and 9% in the clonidine group). By week 3, more than 50% of patients had dropped out of each treatment arm. Three patients in the RD-GA group experienced life-threatening events immediately following general anesthesia, which included pulmonary edema and aspiration pneumonia in one patient, diabetic ketoacidosis in another, and mixed bipolar episode with suicidal ideation that required hospitalization at 5 days in one patient. During the outpatient phase, no group differences occurred in number of urine samples positive for opiates. The authors concluded that general anesthesia for rapid detoxification for rapid antagonist induction does not currently have a meaningful role to play in the treatment of opioid dependence.

### Billing/Coding Information

***Not Covered: Investigational/Experimental/Unproven for this indication***

**CPT CODES**

| | |
|---|---|
| **01999** | Unlisted anesthesia procedure(s) |
| **H0009** | Alcohol and/or drug services; acute detoxification (hospital inpatient) |

**HCPCS CODES**

| | |
|---|---|
| **J2310** | Naloxone injection, per 1 mg |

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## Ultra Rapid Opioid Detoxification (UROD), continued


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MEDICAL POLICY

# WITHDRAWAL MANAGEMENT

Policy # 638
Implementation Date:3/31/20
Review Dates: 11/22/21, 11/10/22, 12/19/23, 12/17/24
Revision Dates: 4/26/24

**Disclaimer:**
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Medicare (CMS), and Select Health Community Care (Medicaid) plans. Refer to the "Policy" section for more information.

## Description

The levels of withdrawal management (WM) are described in the American Society of Addiction Medicine (ASAM) Criteria and InterQual criteria. All levels of WM are integrated with additional behavioral and medical levels of care, as deemed medically necessary, including specialty addiction treatment.

**Ambulatory withdrawal management** (ASAM levels 1, 2.1, and 2.5) is characterized as organized outpatient services which may be delivered in a patient's home, an office setting, a healthcare or addiction treatment facility by trained clinicians who provide medically-supervised evaluation, withdrawal management, and referral services according to a predetermined schedule. Ambulatory WM services are provided in regularly scheduled sessions and should be delivered under a defined set of policies and procedures or medical protocols. Patients receiving care at these levels demonstrate low risk for severe withdrawal.

**Residential withdrawal management** (ASAM levels 3.1, 3.2, 3.3, 3.5, and 3.7) is sometimes synonymous with inpatient treatment. The difference between these two types of programs is the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals. Patients receiving care at these levels demonstrate low risk for severe withdrawal.

**Inpatient withdrawal management** (ASAM level 4) is characterized as hospital care with intensive medical oversight due to active, severe withdrawal symptoms, or the potential for the same.

Select Health adheres to ASAM criteria for outpatient withdrawal management services and InterQual criteria for inpatient withdrawal management services. Discharge is based on the patient demonstrating withdrawal signs and symptoms being sufficiently resolved to be safely managed at a less intensive level of care.

## COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

Application of coverage criteria is dependent upon an individual's benefit coverage at the time of the request.

**A. Select Health covers inpatient withdrawal management when InterQual criteria are met.**

**Select Health covers outpatient withdrawal management services when the following criteria are met**:

1. ASAM criteria* are met.
2. The level of care requested is consistent with the member's medical condition and needs.





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## Withdrawal Management, continued

3. The facility or provider is equipped to provide the level of care necessary for the member's medical condition, including:
    a. Availability of medical evaluation and consultation 24 hours per day.
    b. Adhering to appropriate treatment/transfer practice protocols and guidelines, as well as state and federal law.
    c. Assessment by appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for observation and supervision.
    d. Safe and appropriate staffing levels.

***ASAM Criteria**

| | **Dimension 1 (Acute Intoxication and/or Withdrawal Potential)** | **Dimension 2 (Biomedical Conditions and Complications)** | **Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications** | **Dimension 4 (Readiness to Change)** | **Dimension 5 (Relapse, Continued Use, or Continued Problem Potential)** | **Dimension 6 (Recovery/Living Environment)** |
|---|---|---|---|---|---|---|
| **Level 1 (Outpatient Services)** | Not experiencing significant withdrawal, or at minimal risk of severe withdrawal. Manageable at Level 1-WM. | None, or very stable, or is receiving concurrent medical monitoring | None, or very stable, or is receiving concurrent mental health monitoring. | Ready for recovery but needs motivating and monitoring strategies to strengthen readiness. Or needs ongoing monitoring and disease management. Or high severity in this dimension but not in other dimensions. Needs Level 1 motivational enhancement strategies. | Able to maintain abstinence or control use and/or addictive behaviors and pursue recovery or motivational goals with minimal support | Recovery environment is supportive and/or the patient has skills to cope. |
| **Level 2.1 (Intensive Outpatient Services)** | Minimal risk of severe withdrawal, manageable at Level 2-WM. | None, or not a distraction from treatment. Such problems are manageable at Level 2.1. | Mild severity, with potential to distract from recovery; needs monitoring. | Has variable engagement in treatment, ambivalence, or a lack of awareness of the substance use or mental health problem, and requires a structured program several times a week to promote progress through the stages of change. | Intensification of addiction or mental health symptoms indicate a high likelihood of relapse or continued use or continued problems without close monitoring and support several times a week | Recovery environment is not supportive, but with structure and support and relief from the home environment, the patient can cope. |
| **Level 2.5 (Partial Hospitalization Services)** | Moderate risk of severe withdrawal manageable at Level 2-WM. | None, or not sufficient to distract from treatment. Such problems are manageable at Level 2.5. | Mild-to-moderate severity, with potential to distract from recovery; needs stabilization. | Has poor engagement in treatment, significant ambivalence, or a lack of awareness of the substance use or mental health | Intensification of addiction or mental health symptoms, despite active participation in a Level 1 or 2.1 program, indicates a high likelihood of | Recovery environment is not supportive, but with structure and support and relief from the home environment, the parents can cope |





Select Health

## Withdrawal Management, continued

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| | | | | problem, requiring a near-daily structured program or intensive engagement services to promote progress through the stages of change. | relapse or continued use or continued problems without near-daily monitoring and support | |
| **Level 3.1 (Clinically Managed Low-Intensity Residential Services)** | No withdrawal risk, or minimal or stable withdrawal. Concurrently receiving Level1-WM (minimal) or Level 2-WM (moderate) services. | None, or stable, or receiving concurrent medical monitoring. | None or minimal; not distracting to recovery. If stable, a co-occurring capable program is appropriate. If not, a co-occurring enhanced program is required. | Open to recovery, but needs a structured environment to maintain therapeutic goals. | Understands relapse but needs structure to maintain therapeutic gains | Environment is dangerous, but recovery is achievable if Level 3.1 24-hour structure is available |
| **Level 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services)** | At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3-2 WM. | None, or stable, or receiving concurrent medical monitoring. | Mild-to-moderate severity; needs structure to focus on recovery. | Has little awareness, and needs interventions available only at Level 3.3 to engage and stay in treatment. If there is high severity in Dimension 4, but not in any other dimension, motivational enhancement strategies should be provided in Level 1. | Has little awareness and needs interventions available only at Level 3.3. to prevent continued use, with imminent dangerous consequences, because of cognitive defects or comparable dysfunction | Environment is dangerous, and patient needs 24-hour structure to learn to cope |
| **Level 3.5 (Clinically Managed High-Intensity Residential Services)** | At minimal risk of severe withdrawal. If withdrawal is present, manageable at Level 3-2 WM. | None, or stable, or receiving concurrent medical monitoring. | Demonstrates repeated inability to control impulses, or unstable and dangerous signs/symptoms that require stabilization. Other functioning deficits require stabilization and a 24-hour setting to prepare for community integration and continuing care. A co-occurring enhanced setting is required for | Has marked difficulty with, or opposition to, treatment, with dangerous consequences. If there is high severity in Dimension 4, but not in any other dimension, motivational enhancement strategies should be provided in Level 1. | Has no recognition of the skills needed to prevent continued use, with imminently dangerous consequences | Environment is dangerous and the patient lacks skills to cope outside of a highly structured 24-hour setting |





Select Health

## Withdrawal Management, continued

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| | | | those severe and chronic mental illness. | | | |
| **Level 3.7 (Medically Monitored Intensive Inpatient Services)** | At high risk of withdrawal, but manageable at Level 3.7-WM and does not require the full resources of a licensed hospital. | Requires 24-hour medical monitoring but not intensive treatment. | Moderate severity; needs a 24-hour structured setting. If the patient has a co-occurring mental disorder, requires mental health services in a medically monitored setting. | Low interest in treatment and impulse control is poor, despite negative consequences; needs motivating strategies only safely available in a 24-hour structured setting. If there is a high severity in Dimension 4, but not in any other dimension, motivational enhancement strategies should be provided in Level 1. | Unable to control use, with imminently dangerous consequences, despite active participation at less intensive levels of care | Environment is dangerous and the patient lacks skills to cope outside of a highly structured 24-hour setting |
| **Level 4 (Medically Managed Intensive Inpatient Services)** | At high risk of withdrawal and requires Level 4-WM and the full resources of a licensed hospital. | Requires 24-hour medical and nursing care and the full resources of a licensed hospital. | Because of severe and unstable problems, requires 24-hour psychiatric care with concomitant addiction treatment (co-occurring enhanced). | Problems in this dimension do not qualify the patient for Level 4 services. If the patient's only severity is in Dimension 4,5, and/or 6 without high severity in Dimensions 1,2, and/or 3, then the patient does not qualify for Level 3. | Problems in this dimension do not qualify the patient for Level 4 services. | Problems in this dimension do not qualify the patient for Level 4 services. |

**B. Substance Use Disorder Ambulatory Detoxification Criteria**

Intensity of Service:

Must meet all the following for certification of this level of care throughout the treatment:

1. Services provided by medical personnel** who can monitor withdrawal symptoms and implement physician approved protocols.
2. Evidence of drug screens and relevant lab tests at admission and as clinically indicated.
3. Access for evaluation and consultation by a qualified provider** 24 hours a day.
4. Access to psychiatric and psychological and other supportive services as indicated.
5. After a multidisciplinary assessment, an individualized treatment plan is developed within 24 hours of admission and amended as needed for changes in the individual's clinical condition.

Elements of this plan include, but are not limited to:
a. subjects such as identification of key precipitants for current episode of treatment
b. assessment of psychosocial supports available after discharge,





Select Health

## Withdrawal Management, continued

c. availability of aftercare services in member's home geographic area,
d. potential need for supportive living placement to continue recovery,
e. consideration of the ability of the member/family/support system to meet financial obligations incurred in the discharge plan,
f. need for services for comorbid medical or psychiatric conditions,
g. 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

6. The need for Medication-Assisted Treatment (MAT), unless medically contraindicated, should be critically considered, especially in members who have significant cravings or repeated relapses.
7. Services are delivered face-to-face on an outpatient basis in regularly scheduled sessions.
8. 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 three days of admission.
9. Family/support system coordination as evidenced by contact with family to discuss current treatment as well as support needed to continue treatment at lower levels of care.

**Medical personnel/qualified provider = RN, NP, PA, MD, DO

Admission Criteria: Substance Use Disorder Ambulatory Detoxification

Must meet all the following:

1. A DSM diagnosis of a substance use disorder with withdrawal, which is the primary focus of active daily detoxification treatment.
2. The treatment is not primarily social, custodial, interpersonal, domiciliary or respite care.
3. Specific documentation of current substances used to include:
   a. Substance used
   b. Duration of use
   c. Frequency of use
   d. Last date of use
   e. Quantity used per time period
   f. Urine drug monitoring or breathalyzer documentation of use
4. There are at least three documented signs and symptoms of active moderate withdrawal are present or expectation of such within the next 48 hours, or a historical pattern of withdrawal requiring a 24-hour medical and nursing intervention to prevent potentially life-threatening consequences.

Withdrawal signs include, but are not limited to:

- Temperature > 101 degrees
- Pulse > 110 at rest and BP > 140/90
- Hyperreflexia
- Noticeable, paroxysmal diaphoresis at rest
- Moderate to severe tremor at rest, as observed in outstretched arms

Note: Facilities are required to also provide a validated scale, such as the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) or the Clinical Opiate Withdrawal Scale (COWS)

CIWA scale:

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| Agitation | (0-7) |
| Anxiety | (0-7) |
| Auditory disturbances | (0-7) |
| Headache | (0-7) |
| Clouding of Sensorium | (0-4) |
| Nausea/Vomiting | (0-7) |
| Paroxysmal Sweats | (0-7) |
| Tactile disturbances | (0-7) |
| Tremor | (0-7) |





Select Health

## Withdrawal Management, continued

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| Visual disturbances | (0-7) |

There must be consideration of transition to an inpatient setting when CIWA score has escalated to 16 and above.

COWS scale:

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| Resting Pulse Rate: beats/minute<br>*Measured after patient is sitting or lying for one minute*<br>0 pulse rate 80 or below<br>1 pulse rate 81-100<br>2 pulse rate 101-120<br>4 pulse rate greater than 120 | GI Upset: *over last* 1/2 *hour*<br>0 no GI symptoms<br>1 stomach cramps<br>2 nausea or loose stool<br>3 vomiting or diarrhea<br>5 multiped episodes of diarrhea or vomiting |
| Sweating: *over past* 1/2 *hour not accounted for by room temperature or patient activity.*<br>0 no report of chills or flushing<br>1 subjective report of chills or flushing<br>2 flushed or observable moistness on face<br>3 beads of sweat on brow or face<br>4 sweat off face | Tremor *observation of outstretched hands*<br>0 no tremor<br>1 tremor can be felt, but not observed<br>2 slight tremor observable<br>4 gross tremor or muscle twitching |
| Restlessness *Observation during assessment*<br>0 able to sit still<br>1 reports difficulty sitting still, but is able to do so<br>3 frequent shifting or extraneous movements of legs/arms<br>5 unable to sit still for more than a few seconds | Yawning *Observation during assessment*<br>0 no yawning<br>1 yawning once or twice during assessment<br>2 yawning three or more times during assessment<br>4 several times/minute |
| Pupil size<br>0 pupils pinned or normal size for room light<br>1 pupils possibly larger than normal for room light<br>2 pupils moderately dilated<br>5 pupils so dilated that only the rim of the iris is visible | Anxiety or Irritability<br>0 none<br>1 patient reports increasing irritability or anxiousness<br>2 patient obviously irritable or anxious<br>4 patient so irritable or anxious that participation in the assessment is difficult |
| Bone or Joint aches *if patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*<br>0 not present<br>1 mild diffuse discomfort<br>2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort | Gooseflesh skin<br>0 skin is smooth<br>3 piloerrection of skin can be felt or hairs standing up on arms<br>5 prominent piloerrection |
| Runny nose or tearing *Not accounted for by cold -symptoms or allergies*<br>0 not present<br>1 nasal stuffiness or unusually moist eyes<br>2 nose running or tearing<br>4 nose constantly running or tears streaming down cheeks | Total Score _____<br>The total score is the sum of all 11 items<br>Initials of person completing assessment: _____ |

*Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

There must be consideration of transition to an inpatient setting when COWS score has escalated to 36 or greater.

5. Member has expressed a commitment to ongoing care to address the underlying substance abuse/dependency issues but needs motivating and monitoring strategies.
6. Member has sufficient coping skills and motivation for outpatient detoxification to succeed.
7. Environment is supportive and/or member has the skills to cope with environment.