# Chemical Dependency/Alcoholism Inpatient Coverage Guidelines

**Medicare Advantage Medical Policy** #074
Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025

*Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.*

# When Services May Be Eligible for Coverage

*Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:*

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

**Preauthorization by the Plan is required.**

Based on review of available data, the Health Plan may consider Inpatient Chemical Dependency/Alcoholism Treatment to be **eligible for coverage**** when ALL the following patient selection criteria are met.

<u>Patient Selection Criteria</u>

**Detoxification:**

- There is a high probability or occurrence of medical complications (e.g., delirium, confusion, trauma, or unconsciousness) during detoxification.
- Withdrawal complications or risks necessitates the constant availability of physicians and/or complex medical equipment found only in the hospital setting.
- Hospitalization for more than 5 days must include documentation by a physician substantiating that a longer period of detoxification is reasonable and necessary.

**Rehabilitation:**

- The program must be conducted under the supervision and direction of a physician.
- Patients may enter a rehabilitation program with or without prior hospitalization for detoxification.
- Physician documentation that recent alcohol rehabilitation services in a less intensive setting or on an outpatient basis have proven unsuccessful and, as a consequence, the patient requires the supervision and intensity of services which can only be found in the controlled environment of the hospital, or only the hospital environment can assure the medical management or control of the patient's concomitant conditions during the course of rehabilitation.
- Must be necessary for the care to be provided in the inpatient hospital setting rather than in a less costly facility or on an outpatient basis.

# Policy Guidelines

Generally, detoxification can be accomplished within two to three days with an occasional need for up to five days where the patient's condition dictates. This limit (five days) may be extended in an individual case where there is a need for a longer period for detoxification for a particular patient.

Following detoxification, a patient may be transferred to an inpatient rehabilitation unit or discharged to a residential treatment program or outpatient treatment setting.

Inpatient rehabilitation programs should be composed primarily of coordinated educational and psychotherapeutic services provided on a group basis.

Services should be provided by physicians, psychologists, alcohol/drug counselors, or other qualified staff. Programs must be conducted under the supervision and direction of a physician.

Rehabilitation services must meet the definition of "active treatment" as defined in the Medicare Benefit Policy Manual, Chapter 2, "Inpatient Psychiatric Hospital Services," §20.

Generally, 16-19 days of rehabilitation services are sufficient to allow for continued care in a lower level of care. Extensions beyond this limit should be documented and substantiated by a physician.

When inpatient detoxification and rehabilitation is medically necessary, a 3-week period is generally reasonable to prepare the patient to continue treatment in a lower level of care.

**Basic Requirements for Clinical Appropriateness:**

1. Hospitalization for detoxification will be provided for patients with a high probability or occurrence of medical complications (e.g., delirium, confusion, trauma, or unconsciousness) during detoxification for acute alcoholism or alcohol withdrawal necessitates the constant availability of physicians and/or complex medical equipment found only in the hospital setting.
2. Hospitalization for Chemical Dependency/Alcohol Rehabilitation Patients must require hospital admission for active treatment of chemical dependency/substance use disorder due to physician documentation that recent treatment services at a lower level of care have been unsuccessful, or that the patient's concomitant conditions require medical management and control that can only be provided safely and appropriately in an inpatient hospital setting.

# Background/Overview

**Chemical Dependency/Alcoholism Inpatient Coverage Guidelines**

Instructions for Use: Inpatient Hospital stays for detoxification due to Chemical Dependency/Alcoholism are covered under Medicare in a hospital setting when there is a high probability or occurrence of medical complications. Hospitals may also provide structured inpatient alcohol rehabilitation programs to the chronic alcoholic or chemically dependent patient. Inpatient Chemical Dependency/Alcoholism treatment services must be reasonable and necessary to be

covered by the MA plan. All services are to be provided in accordance with the guidelines established by Medicare.

## Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

## References

1.Medicare Benefit Policy Manual, Chapter 2, Inpatient Psychiatric Hospital Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c02.pdf
2.InterQual Solution. https://www.changehealthcare.com/clinical-decision-support
3.Medicare National Coverage Determinations Manual, Chapter 1, Part 2, Section(s) 130.1 and 130.6.

## Policy History

Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025
11/19/2024 Utilization Management Committee review/approval. New policy.
Next Scheduled Review Date: 02/2026

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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**NOTICE:** If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

**NOTICE:** Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

**NOTICE:** Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

**Medicare Advantage Members**

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

**InterQual®**

Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review staff does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.