**Clinical Practice Guideline:** **Unhealthy Alcohol / Substance Use Screening and Intervention**

**Date of Implementation:** **April 19, 2012**

**Product:** **Specialty**

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## GUIDELINES

Unhealthy alcohol / substance use screenings and interventions by an appropriately trained healthcare professional are established as clinically effective, are professionally recognized, and have a favorable benefit: risk profile.

## INTRODUCTION

Unhealthy alcohol use encompasses a wide range of behaviors, from drinking above the recommended limits (i.e., risky drinking) to alcohol use disorder (AUD) (e.g., harmful **alcohol use**, **abuse**, or **dependence**). Types of unhealthy alcohol use and related terms are numerous and are not mutually exclusive. Examples include Risky/At-risk use, Excessive use, Harmful use, and Alcohol use disorder; for example, persons with AUD may also meet criteria for harmful use. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines "risky use" as exceeding the recommended limits of 4 drinks per day (56 g/d based on the US standard of 14 g/drink) or 14 drinks per week (196 g/d) for healthy adult men aged 21 to 64 years or 3 drinks per day or 7 drinks per week (42 g/d or 98 g/week) for all adult women of any age and men 65 years or older. Excessive alcohol use is defined by the CDC as binge drinking (≥5/4 drinks per occasion for men/women), heavy drinking (≥15/8 drinks per week for men/women), and any alcohol use by people younger than age 21 years and by pregnant women. Per the NIAAA, examples of a standard drink include a 12-oz beer (5% alcohol), 5 oz of wine (12% alcohol), or 1.5 oz of distilled spirits (40% alcohol).

Substance-related disorders are characterized by specific behavioral and physical symptoms, often including withdrawal, tolerance, and craving (DSM-V). The causes of substance-related disorders are multifaceted involving genetic, neurobiological, and psychosocial factors. The early signs of substance-related disorders may not always be evident to health care practitioners, but unhealthy substance use screening can help identify impaired control, social impairment, risky use, and pharmacological criteria. Treatment frequently involves detox, individual or group counseling, and/or medications, however, prevention of the development of substance-related disorders is preferred to reduce healthcare costs and human suffering (National Institute on Alcohol Abuse and Alcoholism, 2021).

## USPSTF SCREENING RECOMMENDATIONS

**Unhealthy Alcohol Use (2018)**

*Grade B Recommendation:* The U.S. Preventive Services Task Force (USPSTF) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

*Grade I Recommendation:* The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years.

**Unhealthy Drug Use (2020)**

*Grade B Recommendation:* The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)

*Grade I Recommendation:* The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents.

***Grade B Recommendation*:** The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

***Grade I Recommendation:*** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

## UNHEALTHY ALCOHOL USE

Benefits of Early Detection and Behavioral Counseling:

The USPSTF found no studies that directly evaluated whether screening for unhealthy alcohol use in primary care settings in adolescents and adults, including pregnant women, leads to reduced unhealthy alcohol use; improved risky behaviors; or improved health, social, or legal outcomes.

The USPSTF found adequate evidence that brief behavioral counseling interventions in adults who screen positive are associated with reduced unhealthy alcohol use. There were reductions in both the odds of exceeding recommended drinking limits and heavy use episodes at 6- to 12-month follow-up. In pregnant women, brief counseling interventions increased the likelihood that women remained abstinent from alcohol use during pregnancy. The magnitude of these benefits is moderate. Epidemiologic literature links

reductions in alcohol use with reductions in risk for morbidity and mortality and provides indirect support that reduced alcohol consumption may help improve some health outcomes.

The USPSTF found inadequate evidence that brief behavioral counseling interventions in adolescents were associated with reduced alcohol use. However, no harms were noted for brief behavioral counseling in the evidence.

Screening Tools—Unhealthy Alcohol Use:

Of the available screening tools, the USPSTF determined that 1- to 3-item screening instruments have the best accuracy for assessing unhealthy alcohol use in adults 18 years or older.1 These instruments include the abbreviated Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) and the NIAAA-recommended Single Alcohol Screening Question (SASQ).When patients screen positive on a brief screening instrument (e.g., SASQ or AUDIT-C), clinicians should ensure follow-up with a more in-depth risk assessment to confirm unhealthy alcohol use and determine the next steps of care. Evidence supports the use of brief instruments with higher sensitivity and lower specificity as initial screening, followed by a longer instrument with greater specificity (e.g., AUDIT). The AUDIT has 10 questions: 3 questions covering frequency of alcohol use, typical amount of alcohol use, and occasions of heavy use, and 7 questions on the signs of alcohol dependence and common problems associated with alcohol use (e.g., being unable to stop once you start drinking). It requires approximately 2 to 5 minutes to administer.1, 12 If AUDIT is used as an initial screening test, clinicians may use a lower cutoff (such as 3, 4, or 5) to balance sensitivity and specificity in screening for the full spectrum of unhealthy alcohol use.

Behavioral Counseling Interventions:

Behavioral counseling interventions for unhealthy alcohol use vary in their specific components, administration, length, and number of interactions. They may include cognitive behavioral strategies, such as action plans, drinking diaries, stress management, or problem solving. Interventions may be delivered by face-to-face sessions, written self-help materials, computer- or Web-based programs, or telephone counseling. For the purposes of this recommendation statement, the USPSTF uses the following definitions of intervention intensity: very brief single contact (≤5 minutes), brief single contact (6 to 15 minutes), brief multicontact (each contact is 6 to 15 minutes), and extended multicontact (≥1 contact, each >15 minutes). Thirty percent of the interventions reviewed by the USPSTF were web-based. Nearly all of the interventions consisted of 4 or fewer sessions; the median number of sessions was 1 (range, 0-21). The median length of time of contact was 30 minutes (range, 1-600 minutes). Most of the interventions had a total contact time of 2 hours or less. Primary care settings often used the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. Most interventions involved giving general feedback to participants (e.g., how their drinking fits with recommended limits, or how to

reduce alcohol use). The most commonly reported intervention component was use of personalized normative feedback sessions, in which participants were shown how their alcohol use compares with that of others; more than half of the included trials and almost all trials in young adults used this technique. Personalized normative feedback was often combined with motivational interviewing or more extensive cognitive behavioral counseling. Other cognitive behavioral strategies, such as drinking diaries, action plans, alcohol use "prescriptions," stress management, or problem solving were also frequently used. The USPSTF was unable to identify specific intervention characteristics or components that were clearly associated with improved outcomes.

**UNHEALTHY DRUG USE**

**Screening Tools**

Several screening tools that ask questions about drug use are available for identifying 1 or more classes of unhealthy drug use, the frequency or severity of use, or drug-related health, social, or legal consequences that characterize unhealthy use or drug use disorders. Interviewer-administered tools and self-administered tools appear to have similar accuracy. Screening tools are not meant to diagnose drug dependence, abuse, addiction, or drug use disorders. Patients with positive screening results may, therefore, need to be offered or referred for diagnostic assessment. Brief tools (e.g., NIDA [National Institute on Drug Abuse] Quick Screen, which asks 4 questions about use of alcohol, tobacco, nonmedical use of prescription drugs, and illegal drugs in the past year) may be more feasible in busy primary care settings, but longer tools (e.g., the 8-item ASSIST [Alcohol, Smoking and Substance Involvement Screening Test]) that assess risks associated with unhealthy drug use or comorbid conditions may reveal information signaling the need for prompt diagnostic assessment. Tools with questions about nonmedical use of prescription drugs (e.g., TAPS [Tobacco, Alcohol, Prescription Medication, and Other Substance Use]) may be useful when clinicians are concerned about prescription misuse. One study reported that drug use questions in the PRO (Prenatal Risk Overview) risk assessment tool were reasonably accurate for identifying drug abuse or dependence in pregnant women.

## CPT Code and Documentation Requirements to Substantiate Medical Necessity

When performing an Alcohol/Substance Screening and Intervention (CPT codes 99408 and 99409) the documentation in the medical records should identify the use of a validated and/or standardized screening questionnaire and the nature and character of the intervention. Please see the Practitioner Resource section below for examples of screening and intervention guidelines.

Medical record documentation should reflect what screening tools were utilized and that the results were reviewed with the patient. The practitioner should provide feedback on the screening results, advice on safe consumption limits and recommendations about behavior change.

If unhealthy substance use is identified through the screening process, the practitioner should provide, at a minimum, feedback about screening results and advice on safe consumption limits and recommended behavior change. A referral for chemical dependency treatment should also be offered or patient's response and plan documented.

**Practitioner Resources**

- CDC's Alcohol Screening and Brief Intervention Efforts (https://www.cdc.gov/ncbddd/fasd/alcohol-screening.html)
- National Institutes on Alcohol Abuse and Alcoholism (http://www.niaaa.nih.gov)
- Substance Abuse and Mental Health Services (https://www.samhsa.gov/)
- National Institute of Drug Abuse (https://nida.nih.gov/)
- Institute for Research, Education, and Training in Addictions (http://ireta.org/)
- https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use

**Member Resources**

Educating patients about substance abuse disorders, treatment options and available resources can assist the recovery process. Publicly available resources can be found at:

- Substance Abuse & Mental Health Services (https://www.samhsa.gov/)
- National Institute on Alcohol Abuse and Alcoholism (https://www.niaaa.nih.gov)

**PRACTITIONER SCOPE AND TRAINING**

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is *best practice* for the practitioner to appropriately render services to a patient only if they are trained to competency, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the patient to the more expert practitioner.

*Best practice* can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a patient's condition and/or symptoms during examination or the course of treatment may indicate the

need for referral to another practitioner or even emergency care. In such cases it is essential for the practitioner to refer the patient for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies in a Health Care Facility (CPG 159 – S)* clinical practice guideline for information.

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