Clinical Practice Guideline: Alcohol / Substance Abuse Screening and Intervention

Date of Implementation: April 19, 2012

Product: Specialty

GUIDELINE

Alcohol and/or Substance Abuse 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 is relatively common and is increasing in adults. 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 also meet criteria for harmful use.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) recommends that men ages 21 to 65 years consume no more than 4 drinks per day (56 g/day, according to the U.S. standard of 14 g/drink) and no more than 14 drinks per week (196 g/day), based on the standard drink amount of a 12-oz beer (5% alcohol), 5 oz of wine (12% alcohol), or 1.5 oz of distilled spirits (40% alcohol). 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.

Substance abuse and addiction are characterized by a strong physiological and emotional reliance on a particular substance. The causes of substance abuse are multifaceted involving genetic, neurobiological, and psychosocial factors. The early signs of substance abuse and drug addiction may not always be evident to health care practitioners, but substance abuse screening can help identify the use of illicit substances. Treatment frequently involves substance abuse counseling, but a more effective approach is substance abuse prevention.

Screening Recommendations

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 B—Recommended: The USPSTF recommends that clinicians provide [the
service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

This recommendation replaces the 2013 recommendation. 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. No harms were noted for brief behavioral counseling in the evidence.

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 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. 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.

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.

**Grade I Statement**—The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.

**Grade I Statement** -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.

**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 substance abuse is found or suspected 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 should also be made.

**Practitioner Resources:**
- National Institutes on Alcohol Abuse and Alcoholism (http://www.niaaa.nih.gov)
- AHRQ Substance Abuse (http://epss.ahrq.gov)
- National Institute of Drug Abuse
- Institute for Research, Education, and Training in Addictions (http://ireta.org/)
- Healthypeople.gov

**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 Administration (http://store.samhsa.gov)
- National Institute of Drug Abuse
- Medline Plus

**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, 2013).

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.

References


O’Connor EA, Perdue LA, Senger CA, Rushkin M, Patnode CD, Bean SI, Jonas DE. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: An Updated Systematic Review for the U.S. Preventive


