Complementary and Alternative Somatic Modalities for the Treatment of Behavioral and Substance Use Disorders

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➲ Instructions for Use

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Application

Optum Behavioral Health Solutions

These Clinical Criteria apply to all lines of business unless superseded by federal or state regulations.

Coverage Rationale

➲ See Benefit Considerations

Complementary and alternative somatic modalities are unproven and not medically necessary for the treatment of emotional, substance use, and/or psychological disorders including, but not limited to:

- Acupuncture
- Brainspotting therapy
- Reiki therapy
- Sauna/niacin/naturopathic detoxification (e.g., New Life Detox)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to

reimbursement or guarantee claim payment. Other clinical criteria may apply.

CPT Codes	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles(s). (List separately in addition to code for primary procedure.)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles(s). (List separately in addition to code for primary procedure.)
90899	Unlisted psychiatric service or procedure

Description of Services

Complementary and Alternative Medicine (CAM) Somatic Modalities for the Treatment of Behavioral and Substance Use Disorders

According to the National Center for Complementary and Integrative Health (NCCIH, 2026), treatments that are "complementary" or "alternative" represent approaches developed outside of mainstream Western, or conventional, medicine. These terms are often used interchangeably, but refer to different concepts:

- If a non-mainstream practice is used together with conventional medicine, it is considered "complementary;"
- If a non-mainstream practice is used in place of conventional medicine, it is considered "alternative."

Acupuncture

Acupuncture describes varying procedures and techniques that involve the stimulation of points on the body. The most studied technique is insertion into the skin with thin, solid, metallic needles that are manipulated by either hands or electrical stimulation. A routine treatment may require 15 to 30 needles with follow-up treatments at 2-week intervals. Most commonly, acupuncture is used for back and neck pain, osteoarthritis, and headache. Research has also been conducted on the use of acupuncture to treat behavioral health conditions, such as depression and substance use disorder.

Brainspotting Therapy

Brainspotting (BSP) is a type of therapy that purports to assist individuals in coping with emotional pain, trauma, anxiety, and depression. During a session, the therapist helps the person find a specific eye position, called a "brainspot," that is connected to a troubling memory or feeling. By focusing on that spot while staying aware of their current thoughts and body sensations, people can begin to process deep emotional stress (Horton et al, 2023).

Naturopathic Detoxification

Naturopathic detoxification therapy (also known as "All-Natural Detox Therapy," "Natural IV Therapy," "Nicotinamide Adenine Dinucleotide (NAD) IV Therapy," "Amino Acid Therapy," "Neurotransmitter Restoration Therapy," "Brain Restoration+," "Gentle Detox," "Easy Detox," etc.) is part of a holistic approach to alcohol and drug addiction treatment. It involves an unknown and non-FDA-approved combination of vitamins, minerals, amino acids, and/or NAD coenzymes, administered intravenously and/or orally. This therapy claims to eliminate cravings from a drug or alcohol addiction and promote recovery. While the actual treatment regimen may vary by site, the following have been identified as common components of a naturopathic detoxification for substance abuse:

- Preadmission assessments, including a medical evaluation
- Laboratory testing to help determine individual need of the patient
- Approximately 10-15 IV infusions in addition to oral therapy – the content of the infusions and oral therapies is unknown

Reiki Therapy

Reiki originates from ancient Japanese healing practices. The theory is that it involves channeling energy to promote balance and well-being across physical, emotional, and psychological levels. It is believed to activate the parasympathetic nervous system, fostering harmony between the body, mind, and spirit. Reiki can be performed in person or remotely, often focusing on the body's seven main chakras, such as those in the head, chest, and abdomen, through either light touch or non-contact methods, typically dedicating a few minutes to each area (Guo et al., 2024).

Sauna/Niacin Detoxification

Sauna/niacin detoxification for substance use disorders (also known as “New Life Detoxification,” “sauna detoxification,” “Purification Rundown/Program,” “Purif,” “Effective Purification Program,” etc.) typically follows a protocol where the following components are delivered on a daily basis):

- Physical exercise
- Sauna, done in 30-minute sessions for up to 5 hours daily
- A multivitamin cocktail, the main ingredient of which is niacin
- Mineral supplements, including calcium, magnesium, iron, zinc, manganese, copper, iodine, and potassium

Treatment programs may be delivered at varying levels of care, depending on the individual patient. The purpose of sauna/niacin detoxification is to eliminate from the body any drug residues and other toxic substances that remain locked in fatty tissues and may be present in the blood stream.

Benefit Considerations

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

Clinical Evidence

Summary of Clinical Evidence

Acupuncture

According to an UpToDate review (2026), while auricular acupuncture shows promise as an adjunctive treatment for major depressive disorder (Rush, 2026), and acupuncture may be beneficial for PTSD (Stein, 2026), both areas require further research to confirm effectiveness, understand mechanisms, and assess long-term outcomes through larger randomized trials.

A systematic review and meta-analysis by Tan et al. (2024) evaluated the efficacy of acupuncture as a standalone treatment for major depressive disorder across 1,376 adult participants, comparing multiple acupuncture modalities (manual, electroacupuncture, scalp, auricular, and intradermal) with standard antidepressant pharmacotherapy (e.g., fluoxetine, sertraline, mirtazapine). Depression severity primary outcomes were measured using the Hamilton Depression Rating Scale (HAM-D), with most interventions conducted over 4–8 weeks. Pooled results demonstrated that acupuncture was associated with significantly greater improvement in depressive symptoms than medication, with a HAM-D response risk ratio (RR) of 1.63 ($p = 0.0002$) and overall treatment efficacy RR of 2.6 ($p = 0.0001$), indicating higher likelihood of clinically meaningful response. While no significant differences were observed during the first 1–3 weeks of treatment, acupuncture showed superior outcomes from week 4 onward, with greater symptom reduction and response rates. Additionally, acupuncture was associated with significantly fewer adverse effects compared to pharmacotherapy. However, the findings are limited by high heterogeneity in acupuncture protocols, challenges with participant blinding, predominance of studies conducted in China, and limited long-term follow-up data (primarily ≤6 weeks, with some extending to 12–24 weeks). Overall, acupuncture has positive results as a short-term treatment option for depression with a favorable safety profile. The authors of the systematic review acknowledge the need for further rigorous and geographically diverse studies to clarify optimal protocols and long-term efficacy.

Hollifield et al. (2024) conducted a two-arm, parallel-group, prospective, blinded randomized clinical trial to evaluate the efficacy of acupuncture for combat-related Posttraumatic Stress Disorder (PTSD). The study enrolled 93 participants (85 men, 8 women), aged 18–55, all diagnosed with combat-related PTSD. Participants were randomized to receive either verum acupuncture or placebo minimal needling. Treatments consisted of 1-hour sessions, administered twice weekly, with up to 24 sessions allowed over 15 weeks. The primary outcome of decreased PTSD symptoms were assessed using the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5). Safety monitoring recorded 64 adverse events, 54 of which

were deemed unrelated to the intervention. Ten participants withdrew from the study, none due to suicidal or homicidal ideation. In the intention-to-treat analysis, verum acupuncture demonstrated a large treatment effect (Cohen's d = 1.17), compared to a moderate effect for sham acupuncture (d = 0.67). The between-group difference favored verum acupuncture (mean difference = 7.1, SD = 11.8; t(90) = 2.87; d = 0.63; P = .005). Similar results were observed in the treatment-completer analysis, with verum showing a large effect size (d = 1.53) versus sham (d = 0.86), and a between-group difference of 7.4 (SD = 11.7); t(69) = 2.64; d = 0.63; P = .01. Verum acupuncture also significantly reduced fear-potentiated startle during the extinction phase, indicating enhanced fear extinction. A modest but significant correlation (r = 0.31) was found between symptom reduction and improved fear extinction. Limitations included the lack of blinding for acupuncturists, the focus on combat veterans, and insufficient data on treatment durability. The researchers of this study suggest that further research is needed to enhance generalizability and assess sustained long-term clinical benefits.

Sun et al. (2023) conducted a systematic review and network meta-analysis to examine safer and nonpharmacological treatments to improve the sleep quality in depressed patients and the depression severity. This study included 26 randomized controlled trials, involving 11 interventions and 3458 depressed participants with a mean age of 49.24. Female participants comprised 60.41% across the studies. The primary outcome was sleep quality with the secondary outcome of depression severity. The sleep scoring tools used for most studies were the Pittsburgh Sleep Quality Index (PSQI) in 13 studies and Insomnia Severity Index (ISI) in 9 studies. The majority of studies used the HAM-D to assess depressive symptoms. The 11 interventions had a minimum intervention duration of 10 days, a maximum duration of 12 weeks, and a mean duration of 6.75 weeks. Results for sleep quality when compared to education only were significant for Cognitive-behavioral therapy (CBT) (SMD: 2.80; 95% CI: 1.63,3.96), aromatherapy (SMD: 3.95; 95% CI: 0.71,7.19), and acupuncture (SMD:3.49; 95% CI: 0.88,6.10). Depression severity results revealed that acupuncture and CBT were more effective than education. Limitations noted among the studies include various scoring tools utilized, a majority of studies lacking allocation blinding, and generalizability. The authors of this study report that future multisite rigorous trial design with large participant sizes are needed to determine efficacy of non-pharmacological interventions for sleep quality, for all severity types of depression.

Liao et al. (2023) performed a double-blinded, randomized controlled crossover study regarding acupuncture efficacy and immune effects for comorbid chronic pain and major depressive disorder. The study comprised 47 adult participants diagnosed with MDD and experiencing persistent pain for more than 3 months. The participants were randomly assigned to two groups: (1) the depression–pain group (23 participants who were treated with depression-specific acupoints and then the pain-specific acupoints after the washout period) and (2) pain–depression group (24 participants with the reverse order). The primary outcomes were a reduction in depression and pain severity. Depressive and pain symptoms were measured with assessment tools Hamilton Depression Rating Scale (HAM-D), Beck Depression Inventory-Second Edition (BDI-II), Brief Pain Inventory (BPI), Neurotoxicity Rating Scale (NRS), Clinical Global Impression (CGI) scale, and World Health Organization Quality of Life Scale Brief Version (WHOQOL-BREF). Participants were assessed at baseline and for weeks 2, 4, 6 (after the first 6-week intervention), 8 (before the start of the second 6-week intervention), 10, 12, and 14 (after the second 6-week intervention). The results show that, after 14-week acupuncture sessions, the pain-specific acupoints did not reduce pain scores per the BPI to a significantly greater degree (-0.97 ± 1.69) than the depression-specific acupoints (-0.28 ± 1.88); likewise, the depression specific acupoints did not significantly improve via the HAM-D (-4.59 ±6.02) compared to the pain-specific acupoints (-6.69 ± 6.61). The pain specific acupoints improved BDI-II (-6.74 ± 9.76) even better than the depression-specific acupoints (-1.92 ± 10.74). The researchers of this study acknowledge that the study results failed to prove their hypothesis that pain-specific acupoints could potentially yield superior analgesic effects than the depression-specific acupoints. Future studies are needed with larger samples sizes to replicate these findings.

Xu et al. (2022) conducted a meta-analysis of randomized controlled trials (RCTs) that compared acupuncture with sham acupuncture, or anti-depressants. Sixty-two studies were reviewed with a total of 2269 adult individuals diagnosed with MDD. Sample sizes ranged from 16–176, with the number of acupuncture sessions ranging from 8-60 and session duration from 2 weeks to 12 weeks. The primary outcome was decreased depressive symptoms by scoring with the Hamilton Depression Rating Scale for Depression (HAMD17/24). Prior to acupuncture treatment and after treatment HAMD scores were measured. The efficacy of the acupuncture sessions was based upon the improvement rate as calculated by the percentage change in HAMD scores when compared to the baseline HAMD measurements. Results showed that after 8 acupuncture sessions, the HAMD score decreased from 17.68 (95% CI: -11.81, -4.80) to 8.30 (95% CI: 14.23–21.13). After 24 acupuncture sessions, a decrease in HAMD scores was observed in 51% of cases (95% CI:48% to 54%). After 36 acupuncture sessions, the effect of improvement in HAMD scores peaked at 66% of cases (95% CI: 59% to 72%).These results imply that the greater number of acupuncture sessions leads to greater clinical outcomes. These findings also suggest that clinical efficacy is not reached until at least 18 acupuncture sessions are completed with 36 sessions showing the optimal symptom improvement for individuals diagnosed with MDD. The majority of limitations among the studies are associated with treatment methodologies such as needle placement, number of needles, duration

and frequency of sessions. The authors of this meta-analysis note that future large, well-designed studies are needed to determine the efficacy of acupuncture, clarify protocols, and establish follow-up data.

Hayes, Inc. (2021) completed a comparative analysis of 47 RCTs regarding acupuncture for the treatment of substance use disorder. The overall quality of evidence was identified as low. Current research shows a potential but unproven benefit. Certain published evidence suggests that safety and impact on health outcomes are at least comparable to standard treatment/testing. However, it remains unclear about safety and/or impact on health outcomes due to poor-quality studies, sparse data, conflicting study results, and applicability in general practice.

Gol et al. (2021) performed a double-blind, three-arm, randomized clinical trial to examine the additive effects of acupuncture to oral selective serotonin reuptake inhibitors (SSRIs) in decreasing anxiety symptoms. Participants (n=105) were divided into 3 groups; SSRIs alone (drug group, n=35), SSRIs with sham acupuncture (control group, n=35) and SSRI with acupuncture (acupuncture group, n=35) and treated for 4 weeks. Among the notable inclusion criteria was a confirmed anxiety disorder, adults aged 18-60 years, and no history of extensive SSRI use. The oral SSRIs prescribed were sertraline, citalopram, and escitalopram. Acupuncture was administered for 20 minute sessions, 3 times per week for 4 weeks. The participants and the psychiatrist were blinded and without knowledge of groupings. The primary outcome was a reduction in anxiety symptoms. Participants were administered the State-Trait Anxiety Inventory (STAI) questionnaire at study start and at day 28. Serum cortisol levels were also monitored before the study and at day 28. STAI total score findings at day 28 indicated significant differences across all 3 groups ($p < 0.001$). The results revealed that SSRIs with acupuncture (acupuncture group) showed the largest improvement in anxiety symptoms per the STAI scores, when compared to the drug group and the control group. Serum cortisol levels were not significantly modified across the 3 groups at baseline and day 28. Although the results show promise, the researchers of this study concluded that future research is needed to establish durability beyond 4 weeks with larger sample sizes to enhance generalizability.

Brainspotting

Horton et al. (2023) conducted a non-randomized controlled study examining Brainspotting (BSP) as a treatment for posttraumatic stress disorder (PTSD). The study included 63 participants (8 men, 52 women, 3 unspecified), with a mean age of 35.15 among those who completed the treatment. Participants were assigned to either Treatment as Usual (TAU; n = 13) or BSP (n = 14) groups. The primary outcome was PTSD symptom severity. Assessments included the PTSD Diagnostic Scale for DSM-5 (PDS-5), Beck Depression Inventory-II (BDI-II), and Beck Anxiety Inventory (BAI), administered at pre-treatment, post-treatment, and follow-up. Results showed that, compared to the TAU group, the BSP group experienced significant decreases in depression and anxiety symptoms over time ($p < .001$ for both). Limitations included a small sample size and variability in clinician technique training. The researchers of this study endorse further research comparing BSP to cognitive-behavioral therapies (CBT) for treating PTSD.

Naturopathic Detoxification

Miller et al. (2012) conducted a pilot study in a residential addiction treatment program involving 129 adults (mean age 39.1 years) diagnosed with substance use disorders, including alcohol and polysubstance dependence. Participants received intravenous KB220 Neuroadaptagen Amino-Acid Therapy (NAAT) plus oral nutritional supplementation, with outcomes measured using the Chronic Abstinence Symptom Severity Scale-Revised (CASS-R). Treatment consisted of approximately five to six IV infusions over seven days, followed by oral supplementation for at least 30 days. The primary outcome was reduction in abstinence-related symptoms, including emotional, somatic, and cognitive symptoms. Results showed significant improvements across all three domains, with greater symptom reduction in the IV-plus-oral group compared with oral therapy alone. Follow-up data from 23 participants indicated sobriety rates of 91% at six months, 82% at one year, and 91% at two years, although relapse-free rates declined over time. Limitations included the small sample size, lack of placebo control, self-selection into treatment groups, and potential follow-up bias. The researchers concluded that KB220IV may be a promising adjunctive treatment for reducing protracted abstinence symptoms and supporting recovery but emphasized that larger randomized controlled trials are needed to confirm these findings.

Reiki Therapy

Liu et al. (2025) conducted a meta-analysis of RCTs assessing the effects of Reiki therapy on quality of life (QOL) among adolescents (>14 years) and adults (N=661) experiencing reduced QOL due to stress, anxiety, pain, and fatigue. Interventions typically involved more than eight Reiki sessions lasting 20–60 minutes over 1–6 weeks, compared with no treatment, usual care, or sham Reiki controls. The primary outcome was QOL following Reiki therapy. Outcomes were measured using validated QOL instruments such as the Short Form Health Survey (SF-36), World Health Organization Quality of Life – Brief Version (WHOQOL-BREF), and Quality of Life Scale (QOLS). Meta-analysis demonstrated a small but statistically significant improvement in overall QOL (SMD = 0.28; 95% CI: 0.01–0.56; $p = 0.043$), though heterogeneity was moderate to high ($I^2 = 65.1\%$). Interpretation is limited by variability in study populations, intervention dosing, and

outcome measures, as well as methodological concerns including lack of blinding, inconsistent reporting, and mixed results across individual studies. Additionally, the absence of robust follow-up data limits conclusions regarding durability of effects, and QOL outcomes are inherently influenced by multiple contextual factors. In conclusion, Reiki may produce modest improvements in quality of life, but current evidence is constrained by heterogeneity and low methodological rigor. The authors of this meta-analysis underscore the need for more standardized, high-quality trials to establish clinical effectiveness and optimal treatment parameters.

Guo et al. (2024) conducted a meta-analysis to evaluate the efficacy of Reiki therapy in treating anxiety. The review encompassed 13 RCTs involving a total of 824 adult participants (aged 18 years and older) diagnosed with various forms of anxiety. Of these studies, ten focused on individuals with chronic illnesses, cancer, or those undergoing surgical procedures, while three included healthy adults. Sample sizes across studies ranged from 7 to 105 participants. Reiki therapy was administered at varying frequencies, ranging from once to six times per week—with session durations between 25 and 60 minutes. The primary outcome was anxiety reduction. A range of validated assessment tools was employed to measure anxiety outcomes, including the State Anxiety Inventory (SAI), Hamilton Anxiety Scale (HAM-A), State-Trait Anxiety Inventory (STAI), Hospital Anxiety and Depression Scale (HADS), and Quality of Life and Neurotoxicity (QLN) measures. The meta-analysis revealed a statistically significant reduction in anxiety following Reiki therapy (SMD = -0.82, 95% CI: -1.28 to -0.36, p = 0.001). Subgroup analysis indicated that short-term interventions (fewer than three sessions) and moderate interventions (six to eight sessions) were particularly effective in reducing anxiety related to medical procedures among chronically ill individuals. The authors of this study noted several limitations, including variability in intervention protocols, small sample sizes, and a lack of long-term follow-up data. The authors concluded that further research is warranted to better understand the effectiveness of Reiki therapy across different diagnoses and individual patient contexts.

Sauna/Niacin Detoxification

Hussain et al. (2018) examined the role of saunas, or whole-body thermotherapy as potential treatment for various health issues. Information was obtained using a voluntary online 71-item questionnaire on the individual characteristics, sauna-related habits, and perceived health and wellness experiences of regular sauna bathers. The study was conducted from October 2016 to October 2017. The primary outcome was quality of life and well-being. The validated Short Form (SF-12) quality of life scoring tool was integrated into the questionnaire to measure physical and mental indicators of well-being. There were 482 valid responses recorded from around the world, with the age range of 17-80 years. Respondents sauna bathed approximately of 4–12 times each month (median of 6 times, n=443), which extrapolates to a frequency of approximately 1–2 occasions per week. Respondents reported one or more medically-diagnosed health conditions (32.1%, n=135/420). This study identified that sauna use has perceived health benefits that vary from relaxation, stress, relief, invigoration, and socializing to more specific health advantages such as aiding circulation, improving sleep, improving mental health, enhancing 'detoxification,' and relieving back/musculoskeletal pain. The few reported incidences of adverse reactions to sauna bathing were mild. This study demonstrates that the use of a sauna for health purposes is not well established in the scientific community. The authors of the survey study acknowledge numerous limitations of this study and recommend further research surrounding the use of saunas for improving health.

Lennox and Cecchini-Sternquist (2018) completed a prospective chart review of 109 individuals sequentially enrolled into the Hubbard sauna regimen as part of a multi-modal, long-term residential substance abuse treatment facility. The Hubbard regimen is based on exercise, sauna, and therapeutic nutrients. The primary outcome was health-related quality of life. Data from medical charts, client self-reports and Short Form Health Survey (SF-36) responses indicated that the Hubbard sauna detoxification method was well tolerated, with a 99% completion rate, including 1 human immunodeficiency virus and 9 hepatitis C positive subjects. Statistically significant improvements were identified in both mental and physical SF-36 scores at regimen completion, in addition to the Addiction Severity Index and Global Appraisal of Individual Needs Short Screener change scores at rehabilitation program discharge, compared with enrollment. There were no serious medical complications, a very low discontinuation rate, and high participant satisfaction. The SF-36 results indicated improved physical and emotional symptoms. The authors of this chart review recommend further research into this sauna-based treatment regimen. Future research should focus on additional outcomes measurements of physical and mental health changes with analysis of whether these are improved via toxic elimination, nutrient and systems restoration, or a combination of these methods.

Guidelines & Consensus Statements

The Department of Veterans Affairs and Department of Defense (VA/DoD)

- Clinical Practice Guidelines for the Management of Major Depressive Disorder (2022) indicates the following for complementary and alternative treatments:

    - For patients with major depressive disorder (MDD), there is insufficient evidence to recommend for or against acupuncture as an adjunctive treatment to pharmacotherapy.
    - For patients with MDD, there is insufficient evidence to recommend for or against yoga, tai chi, or qi gong as an adjunctive treatment to pharmacotherapy.
- Clinical Practice Guidelines for the Management Posttraumatic Stress Disorder And Acute Stress Disorder (2023):
    - There is insufficient evidence to recommend for or against acupuncture for the treatment of PTSD.

U.S. Food and Drug Administration

The following modalities are not subject to U.S. Food and Drug Administration (FDA) regulation:
- Brainspotting Therapy
- Reiki Therapy

Naturopathic detoxification and sauna/niacin detoxification protocols are not FDA-regulated treatments. However, products used in these protocols (e.g., dietary supplements, drugs, or medical devices) may be subject to FDA regulation depending on their composition, intended use, and marketing claims. For additional information: FDA Dietary Supplements, FDA Medical Devices.

Acupuncture needles are regulated by the FDA as Class II medical devices. See for additional information: 21 CFR § 880.5580 – Acupuncture Needle.

Centers for Medicare and Medicaid Services

Medicare does not have a National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs) for the following complementary and alternative medicine modalities used in treating behavioral disorders and/or substance use:
- Brainspotting Therapy
- Reiki Therapy
- Sauna/niacin/naturopathic detoxification (e.g., New Life Detox)

Medicare does address acupuncture and is only covered for chronic low back pain. Refer to the following NCDs (www.CMS.gov):
- NCD for Acupuncture (30.3)
- NCD for Acupuncture for Fibromyalgia (30.3.1)
- NCD for Acupuncture for Osteoarthritis (30.3.2)
- NCD for Acupuncture for Chronic Lower Back Pain (30.3.3)

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Policy History/Revision Information

Date	Summary of Changes
07/18/2023	Annual review: updated references/sourcing.

Date	Summary of Changes
12/12/2023	Reinstated the following topics per CTAC: • Naturopathic detoxification • Sauna/niacin detoxification (e.g., New Life Detox)
06/18/2024	Annual review: added Animal-Assisted Therapy information; updated references/sourcing.
07/22/2025	Annual review: Approved by Optum committees on 6/16/2025 and 07/22/2025 • Added Brainspotting Therapy • Added Reiki Therapy • Updated references/sourcing
07/21/2026	Annual Review: Approved by Optum committees on 07/07/2025 and 07/21/2026 • Separated Complementary and Alternative topics into 2 BCPs: • Complementary and Alternative Psychotherapeutic Modalities for the Treatment of Behavioral and Substance Use Disorders • Complementary and Alternative Somatic Modalities for the Treatment of Behavioral and Substance Use Disorders

Appendix

Additional resources considered in support of this policy:

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Instructions for Use

Behavioral Clinical Policies are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®.

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices

and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in Clinical Criteria. This guideline is provided for informational purposes. It does not constitute medical advice.