CHEMICAL AVERSION THERAPY (CAT) FOR ALCOHOL ADDICTION

Policy Number: BH727CATBCP_042017  Effective Date: April 11, 2017

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INSTRUCTIONS FOR USE

This Behavioral Clinical Policy provides assistance in interpreting and administering behavioral health benefit plans that are managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California (“Optum-CA”). When deciding coverage, the member-specific benefit plan document must be referenced. The terms of the member-specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Behavioral Clinical Policy is based. In the event of a conflict, the member's specific benefit plan document supersedes this Behavioral Clinical Policy.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the COC/SPD prior to using this Behavioral Clinical Policy. Other Policies and Coverage Determination Guidelines may apply. Optum reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This Behavioral Clinical Policy is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

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

Additional Information

The lack of a specific exclusion for a service does not necessarily mean that the service is covered. For example, depending on the specific plan requirements, services that are inconsistent with Level of Care Guidelines and/or prevailing medical standards and clinical guidelines may be excluded. Please refer to the member's benefit document for specific plan requirements.

Prior Authorization and Pre-Service Notification
Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require prior authorization or pre-service notification, depending on the member-specific benefit plan. Notification of a scheduled admission must occur at least five (5) business days before admission. Notification of an unscheduled admission (including emergency admissions) should occur as soon as is reasonably possible. Benefits may be reduced if Optum is not notified of an admission to these levels of care. Check the member’s specific benefit plan document for the applicable penalty and provision of a grace period before applying a penalty for failure to notify Optum as required.

**Essential Health Benefits for Individual and Small Group**

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this policy, it is important to refer to the member-specific benefit document to determine benefit coverage.

**COVERAGE RATIONALE**

**Chemical aversion therapy is unproven and not medically necessary for the treatment of alcohol and/or other substance addiction.**

The efficacy of chemical aversion therapy has not been established in well-designed controlled trials, and this technique has not been directly compared to other generally-accepted, first-line treatments for alcohol addiction.

The requested service or procedure must be reviewed against the language in the member’s benefit document. When the requested service or procedure is limited or excluded from the member’s benefit document, or is otherwise defined differently, it is the terms of the member’s benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with Level of Care Guidelines and/or evidence-based clinical guidelines.

All services must be provided by or under the direction of a properly qualified behavioral health provider.

**DESCRIPTION OF SERVICES**

Chemical aversion therapy (CAT) is a form of psychological treatment that pairs the ingestion of alcohol with an aversive response agent (such as disulfiram) to cause some form of discomfort, usually nausea and/or vomiting. Over the course of treatment, conditioning occurs so that alcohol alone promotes the aversive response. The treatment is generally provided as a component of a 10-day inpatient program which may include other interventions, such as counseling and narcotherapy (Pentothal interview). CAT is distinct from disulfiram pharmacotherapy, which produces acute sensitivity to drinking alcohol, but does not include aversion counter-conditioning.

**CLINICAL EVIDENCE**

**Summary of Clinical Evidence** The efficacy of chemical aversion therapy has not been established in well-designed controlled trials. Studies on CAT from the early 1990s are primarily retrospective analyses and long-term telephonic follow-ups with patients receiving prior treatment. There are no studies available that compare the multimodal inpatient treatment program to other treatments for alcohol and drug addiction.

**Clinical Trials**

Smith and Frawley (1993) followed-up with a sample of 600 patients treated in a multimodal treatment program using aversion therapy and narcotherapy. Contact with patients was made a minimum of 12 months and as many as 20 months after completion of treatment (mean of 14.7 months). For follow-up, telephone contact was made with 427 of the patients (71.2%). Of these 427 individuals, 65.1% reported being totally abstinent for 1 year after treatment, and 60.2% abstinent at 14.7 months after treatment. Of those patients (n = 213) who reported alcohol as their only drug problem, the 12-month abstinence rate was 69% and the total abstinence rate was 65.3%. The authors note that a powerful predictor of long-term abstinence was whether or not the patient completed reinforcement treatment, and also noted that at least some degree of support group attendance after completion of the initial inpatient treatment program is also associated with increased abstinence rates.
Frawley and Smith (1990) conducted a pilot feasibility study of chemical aversion therapy among twenty patients treated for cocaine (n = 9) or cocaine/alcohol (n = 11) to determine the possibility of integrating chemical aversion therapy into a multimodal treatment protocol. The average number of drinks per occasion was 11.6 (range 3-30) and average number duration of the alcohol problem was 11.6 years. Patients completed a program which included chemcal aversion to develop a conditioned aversion to the sight, smell, and taste of a cocaine substitute. The authors reported no adverse effects during the treatment period. All but two patients returned for their first reinforcement treatment one month later, with sixteen of them completing a first reinforcement. Of the original 20 patients, a total of 9 returned for the second reinforcement treatment three months later. At this time, all received one day of chemical aversion for cocaine or cocaine/alcohol, and one day for a sodium pentothal intervention as well as group and individual counseling. Primary treatment goal was abstinence from cocaine or cocaine/alcohol use. At six months, 19 of the patients were contacted, with 56% of the cocaine only group and 70% of the cocaine/alcohol group reporting total abstinence. At 18 months, patients were contacted, with 38% of the cocaine only group and 50% of the cocaine/alcohol group reporting total abstinence. The authors conclude that chemical aversion therapy in this pilot study was shown to have high patient acceptability and to be associated with good patient outcomes when used as part of a multimodal treatment program. The authors note a number of limitations: this was a preliminary study in which only a small number of patients participated; there was also no matched control group assigned to no treatment or some other form of treatment.

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Professional Societies

American Academy of Child & Adolescent Psychiatry (AACAP): A 2005 practice parameter for the assessment and treatment of children and adolescents with substance use disorders recommends that “medication can be used when indicated for the management of craving and withdrawal and for aversion therapy...medications used to target alcohol-related cravings...and aversive agents such as disulfiram could be considered for use in treatment-resistant adolescents.”

American Psychiatric Association (APA): A 2006 practice guideline for the treatment of patients with substance use disorders states that “compared with positive reward approaches, aversive therapies have been less successful. Only a small number of studies have documented the efficacy for aversion therapy using nausea or electric shock” (Kleber et al 2007).
Chemical aversion therapy is a procedure and not subject to Food and Drug Administration (FDA) regulations. None of the drugs have been specifically approved by the FDA for use in chemical aversion therapy.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

A National Coverage Determination exists for Chemical Aversion Therapy for Treatment of Alcoholism:

**Item/Service Description**
Chemical aversion therapy is a behavior modification technique that is used in the treatment of alcoholism. Chemical aversion therapy facilitates alcohol abstinence through the development of conditioned aversions to the taste, smell, and sight of alcohol beverages. This is accomplished by repeatedly pairing alcohol with unpleasant symptoms (e.g., nausea) which have been induced by one of several chemical agents. While a number of drugs have been employed in chemical aversion therapy, the three most commonly 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 alcoholism. Accordingly, when these drugs are being employed in conjunction with this therapy, patients undergoing this treatment need to be kept under medical observation.

**Indications and Limitations of Coverage**
Available evidence indicates that chemical aversion therapy may be an effective component of certain alcoholism treatment programs, particularly as part of multi-modality treatment programs which include other behavioral techniques and therapies, such as psychotherapy. Based on this evidence, the Centers for Medicare & Medicaid Services’ medical consultants have recommended that chemical aversion therapy be covered under Medicare. However, since chemical aversion therapy is a demanding therapy which may not be appropriate for all Medicare beneficiaries needing treatment for alcoholism, a physician should certify to the appropriateness of chemical aversion therapy in the individual case. Therefore, if chemical aversion therapy for treatment of alcoholism is determined to be reasonable and necessary for an individual patient, it is covered under Medicare.

When it is medically necessary for a patient to receive chemical aversion therapy as a hospital inpatient, coverage for care in that setting is available. Follow-up treatments for chemical aversion therapy can generally be provided on an outpatient basis. Thus, where a patient is admitted as an inpatient for receipt of chemical aversion therapy, there must be documentation by the physician of the need in the individual case for the inpatient hospital admission.

**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 Policies and Coverage Determination Guidelines may apply.

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>90899</td>
<td>Unlisted psychiatric service or procedure</td>
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*CPT® is a registered trademark of the American Medical Association*

**REFERENCES**


ADDITIONAL RESOURCES

Clinical Protocols
Optum maintains clinical protocols that include the Level of Care Guidelines and Best Practice Guidelines which describe the scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding treatment. These clinical protocols are available to Covered Persons upon request, and to Physicians and other behavioral health care professionals on www.providerexpress.com.

Peer Review
Optum will offer a peer review to the provider when services do not appear to conform to this policy. The purpose of a peer review is to allow the provider the opportunity to share additional or new information about the case to assist the Peer Reviewer in making a determination including, when necessary, to clarify a diagnosis.

Second Opinion Evaluations
Optum facilitates obtaining a second opinion evaluation when requested by an member, provider, or when Optum otherwise determines that a second opinion is necessary to make a determination, clarify a diagnosis or improve treatment planning and care for the member.

Referral Assistance
Optum provides assistance with accessing care when then provider and/or member determine that there is not an appropriate match with the member’s clinical needs and goals, or if additional providers should be involved in delivering treatment.

HISTORY/REVISION INFORMATION

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