ULTRARAPID DETOXIFICATION

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Related Clinical Policies & Guidelines:
- Complementary & Alternative Medicine (CAM)
- Office-Based Opioid Treatment
- Opioid Treatment Program (maintenance)
- Substance-Related and Addictive Disorders

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 OptumHealth 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.

Pre-Service Notification
Admissions to an inpatient, residential treatment center, intensive outpatient, or a partial hospital/day treatment program require pre-service notification. 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.

Additional Information

Ultrarapid Detoxification
Optum Behavioral Clinical Policy

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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.

**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**

**Ultrarapid detoxification is unproven and not medically necessary at all levels of care for withdrawal from opioid dependence.**

The efficacy of ultrarapid detoxification has not been established in well-designed controlled trials, and a number of safety concerns have been noted for this service. The FDA states that adverse events, including death, have been reported with ultrarapid opiate detoxification programs. The risks of this service outweigh any potential benefits, and there are other generally-accepted, first-line treatments available.

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.

**DEFINITIONS**

**Diagnostic and Statistical Manual of Mental Disorders (DSM):** A manual produced by the American Psychiatric Association which provides the diagnostic criteria for mental health and substance-related disorders and other problems that may be the focus of clinical attention. Unless otherwise noted, the current edition of the DSM applies.

**Proven Services:** Services or technologies that, after a review of the evidence, demonstrate they can be safely and effectively administered to a defined patient population, under a set of specific conditions that are clearly identified. A service found to be proven does not necessarily indicate that the service is covered. The member’s specific benefit plan must be referenced to determine coverage, limitations, and exclusions.

**Scientific Evidence:** The results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.

**Unproven Services:** Services including medications that are not consistent with prevailing medical research that has determined the services to not be effective for treatment of the condition and/or not to have the beneficial effect on behavioral health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed literature. Unproven services and all services related to unproven services are typically excluded. The fact that an unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be unproven in the treatment of that particular condition.

**DESCRIPTION OF SERVICES**

Ultrarapid Detoxification is the use of general anesthesia in conjunction with an opioid antagonist in order to achieve a medically supervised withdrawal from opioid dependence. Ultrarapid detoxification may be known by other terms in the research literature, such as “URD”, “UROD”, “one-day detoxification”, “anesthesia-assisted detoxification”, etc.
According to the Substance Abuse and Mental Health Services Administration (2006), rapid methods of detoxification have at their core the use of narcotic antagonists; for example, naloxone, naltrexone, or nalmefene, to precipitate narcotic withdrawal by displacing exogenous opioids (those not produced by the body itself) from the receptor sites.

**CLINICAL EVIDENCE**

**Summary of Clinical Evidence**
The efficacy of ultrarapid detoxification has not been established in well-designed controlled trials, and a number of safety concerns have been noted for this service.

Salimi and colleagues (2014) assessed ultrarapid opioid detoxification (UROD) efficacy, and estimated the relapse rate over a 2-year follow-up period. A total of 424 opioid-addicted, self-reporting patients were enrolled in the study and entered the UROD program, with 400 patients completing the program. Patients were scheduled for follow-up visits every 3 months for a 2-year period. Of the patients completing the program, 76% were considered to be successful, with 24% relapsing. No patients in the relapse group continued naltrexone maintenance at 6-month follow-up, compared to 76% of the successful group. The authors conclude that UROD could be an effective method of detoxification in addicted patients, but case selection, adherence to guidelines, and maintenance therapy accompanied with social support is necessary to minimize relapse and withdrawal symptoms.

Forozeshfard and colleagues (2014) conducted a follow-up study to investigate and follow the outcome of patients who undergo ultrarapid opiate detoxification (UROD). A total of 64 patients (mean age of 31 years) who previously underwent UROD were evaluated one month after the detoxification, with 75% of patients reporting relapse. At six month follow-up, all patients had relapsed and restarted using opiates routinely. The authors conclude that, if used alone, UROD has a very high relapse rate in the long-term.

Sigmon and colleagues (2014) summarized opinions from several expert clinicians and scientists into recommendations for conducting opioid detoxification and naltrexone induction. The authors state that while various regimens have been developed using heavy sedation or general anesthesia, there is no consistent evidence that such ultrarapid detoxification methods produce better outcomes than more gradual approaches to detoxification. Further, the authors note that ultrarapid induction procedures have produced life-threatening adverse events, including aspiration pneumonia, pulmonary edema, diabetic ketoacidosis, and sudden death. The authors state that ultrarapid detoxification cannot be recommended.

Safari and colleagues (2010) examined the effect of ultrarapid opiate detoxification (UROD) on the presence or absence of withdrawal syndrome in a group of patients with opiate dependency. A total of 173 patients with opiate addition had their withdrawal syndrome evaluated before and after UROD using the Objective Opioid Withdrawal Scale. Specifically, each patient was observed for 5 minutes before UROD and at different hours afterward to observe any withdrawal sign. Results found that patients with opioid dependency who underwent UROD showed the highest rate of withdrawal symptoms at one hour after anesthesia, and that most of these symptoms subsided after 24 hours.

Gowing and colleagues (2010) conducted a Cochrane Review to assess the effectiveness of opioid antagonists to induce opioid withdrawal with concomitant heavy sedation or anesthesia. Primary outcome measures included withdrawal signs and symptoms, completion of treatment, and adverse effects. The authors included all controlled studies of antagonist-induced withdrawal under heavy sedation or anesthesia in opioid-dependent participants, compared with other approaches, or different regimes of anesthesia-based antagonists-induced withdrawal. A total of nine studies (including 8 randomized controlled trials) were included in the review, involving 1109 total participants. Results found that antagonist-induced withdrawal is more intense but less prolonged than withdrawal managed with reducing doses of methadone. Also, there is a significantly greater risk of adverse events with heavy, compared to light, sedation. The authors conclude that heavy sedation compared to light sedation does not confer additional benefits in terms of less severe withdrawal or increased rates of commencement on naltrexone maintenance treatment. They note that, given that the adverse events are potentially life-threatening, the value of antagonist-induced withdrawal under heavy sedation or anesthesia is not supported.

Favrat and colleagues (2006) conducted a randomized clinical trial to evaluate the effectiveness of detoxification under anesthesia compared to traditional detoxification procedures. A total of 70 patients with opiate dependence received detoxification: 36 were randomized to opioid antagonist detoxification (RODA; with treatment as allocated received by 26). Another 34 patients were randomized to classical clonidine detoxification (with treatment as allocated received by 21). Primary outcome measures were successful detoxification, safety, and self-reported abstinence at 3, 6, and 12 months after detoxification. Results found that no complications were reported during or after anesthesia administration. According to the intention to treat analysis, 78% of RODA patients and 62% of clonidine patients successfully completed the detoxification process. In the intention to treat analysis, 30% of RODA patients were abstinent after 3 months, compared to 14% in the clonidine group. No differences were found at 6 and 12 months (with both groups showing less than 5% abstinence after 12 months). The authors conclude that although the
detoxification success rate and abstinence after 3 months were slightly better for the RODA procedure, these differences were not statistically significant, and disappeared completely after 6 and 12 months.

Collins and colleagues (2005) conducted a randomized controlled trial to evaluate the safety, tolerability, and efficacy of anesthesia-assisted rapid opioid detoxification compared with two inpatient withdrawal and naltrexone induction procedures. A total of 106 treatment-seeking heroin-dependent patients, were assigned to either anesthesia-assisted rapid opioid detoxification with naltrexone induction (n = 35), buprenorphine-assisted rapid opioid detoxification with naltrexone induction (n = 37), and clonidine-assisted opioid detoxification with delayed naltrexone induction (n = 34). Outcome measures included withdrawal severity scores on objective and subjective scales; proportions of patients receiving naltrexone completing inpatient detoxification and retained in treatment; and proportion of opioid-positive urine specimens. Results found that mean withdrawal severities were comparable across the 3 treatments. Groups did not differ in rates of completion of inpatient detoxification, treatment retention over 12 weeks, or opioid-positive urine specimens. The authors conclude that the data do not support the use of general anesthesia for heroin detoxification and rapid opioid antagonist induction.

Krabbe and colleagues (2003) conducted a prospective clinical trial to study abstinence rates and withdrawal effects of rapid detoxification of opioid-dependents under general anesthesia (RD-GA), compared to standard methadone tapering (SMT). A total of 30 subjects participated, with the first 15 assigned to the RD-GA group, and the next 15 to the SMT group. The RD-GA group received methadone substitution to bridge the waiting period. For the detoxification, subjects were given 100 mg of oral naltrexone, and general anesthesia was induced with propofol. A maintenance dosage of naltrexone 50mg was given daily under supervision for a period of 3 months to prevent relapse. A subsequent group of 15 subjects received SMT over 1-2 weeks. After the last dose of methadone, these subjects also started taking 50 mg naltrexone per day for a period of 3 months. Outcome measures included urine toxicology screening and subjective opioid withdrawal distress symptoms. Results found that statistically significant differences in abstinence rate between RD-GA and SMT were present after 1 and 2 months. After 3 months, this difference was no longer statistically significant. Objective and subjective withdrawal symptoms showed largely identical outcomes and were equally low in the two groups. The authors caution that more persistent dependents may have presented themselves for this preliminary study, and could therefore have been more motivated. They conclude that RD-GA followed by naltrexone use can be suitable for motivated, socially and emotionally stable opiate users whose main obstacle in the pursuit of abstinence is apprehension of withdrawal symptoms.

**Professional Societies**

**American Society of Addiction Medicine (ASAM):** In a public policy statement on rapid and ultrarapid opioid detoxification, the American Society of Addiction Medicine states that "Ultrarapid opioid detoxification (UROD) is a procedure with uncertain risks and benefits, and its use in clinical settings is not supportable until a clearly positive risk-benefit relationship can be demonstrated. Further research on UROD should be conducted."

**Substance Abuse and Mental Health Services Administration (SAMHSA):** In a TIP Protocol titled *Detoxification and Substance Abuse Treatment*, SAMHSA states that "...there are few data showing that the rapid or ultrarapid methods of opioid detoxification show a positive correlation with the likelihood of a patient’s being abstinent a few months later." The Protocol also notes "...although the ultrarapid procedure under anesthesia has received wide publicity, controlled studies that would make it possible to evaluate the risk/benefit ratio are absent. The procedure is still unproven and controversial."

**World Federation of Societies of Biological Psychiatry (WFSBP):** The WFSBP published *Guidelines for the Biological Treatment of Substance Use and Related Disorders*, which state "...there is no convincing evidence for the use of opioid antagonists plus clonidine under heavy sedation. Given the lack of evidence for a substantial advantage of this approach, the associated risks and costs do not appear to be justified."

**World Health Organization:** In their *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*, the World Health Organization states "...accelerated withdrawal techniques using opioid antagonists in combination with heavy sedation are not recommended because of safety concerns."
Ultrarapid detoxification is a procedure and not subject to Food and Drug Administration (FDA) regulations. However, anesthetic devices, anesthetic agents, and various opioid antagonists are subject to FDA approval.

Documents posted on the FDA’s website note that safe use naltrexone HCL in ultrarapid opiate detoxification programs has not been established...and that adverse events, including withdrawal symptoms and death, have been reported with its use in ultrarapid opiate detoxification programs. The cause of death in these cases is not known.

FDA documents note that naltrexone HCL is reported to be of greatest use in good prognosis opioid addicts who take the drug as part of a comprehensive occupational rehabilitative program, behavioral contract, or other compliance-enhancing protocol...and has not been shown to provide any therapeutic benefit except as part of an appropriate plan of management for the addictions.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

National Coverage Determinations exist for the treatment of alcoholism and drug abuse in a freestanding clinic, treatment of drug abuse, and withdrawal treatments for narcotic addictions.

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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<td>292.0</td>
<td>F11.23</td>
<td>Opioid withdrawal</td>
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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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