**Ambulatory Treatment of Opioid Dependence With Buprenorphine or Naltrexone**

**Guideline Number:** BHCDG382014  
**Product:**
- 2001 Generic UnitedHealthcare COC/SPD  
- 2007 Generic UnitedHealthcare COC/SPD  
- 2009 Generic UnitedHealthcare COC/SPD  
- 2011 Generic UnitedHealthcare COC/SPD  
- May also be applicable to other health plans and products

**Effective Date:** December, 2010  
**Revised Date:** October, 2014

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**Related Medical Policies:**
- Level of Care Guidelines  
- American Psychiatric Association, Practice Guideline for the Treatment of Patients with Substance Use Disorders, 2006  
- American Psychiatric Association, Guideline Watch for the Treatment of Patients with Substance Use Disorders, 2007  

**INSTRUCTIONS FOR USE**

This Coverage Determination Guideline provides assistance in interpreting behavioral health benefit plans that are managed by Optum. This Coverage Determination Guideline is also applicable to behavioral health benefit plans managed by Pacificare Behavioral Health and U.S. Behavioral Health Plan, California doing business as Optum of California (“Optum-CA”).

When deciding coverage, the enrollee specific document must be referenced. The terms of an enrollee’s document (e.g., Certificates of Coverage (COCs), Schedules of Benefits (SOBs), or Summary Plan Descriptions (SPDs) may differ greatly from the standard benefit plans upon which this guideline is based. 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 document and the COC/SPD, the enrollee's specific benefit document supersedes these guidelines.
Key Points

- According to the DSM, the essential feature of a Substance-Related Disorder is a problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period (Diagnostic and Statistical Manual of Mental Disorders, 5th ed.; DSM-5; American Psychiatric Association, 2013):
  - The substance(s) is taken in larger amounts or over a longer period than was intended;
  - There is a persistent desire or unsuccessful efforts to cut down or control substance use;
  - A great deal of time is spent in activities necessary to obtain substances, use substances, or recover from the effects of substance use;
  - Craving, or a strong desire or urge to use substances;
  - Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home;
  - Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance(s);
  - Important social, occupational, or recreational activities are given up or reduced because of substance use;
  - Recurrent use in situations in which it is physically hazardous;
  - Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance use;
  - Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of substances to achieve intoxication or desired effect;
    - A markedly diminished effect with continued use of the same amount.
  - Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for the substance used according to DSM-5;
    - Other substances are used to relieve or avoid withdrawal symptoms.

- Medication-assisted ambulatory treatment of Opioid Dependence encompasses induction, stabilization and maintenance and may be delivered as a unique service, or as part of a larger comprehensive ambulatory treatment plan. Community resources such as self-help, peer support groups, consumer-run services, and preventive health programs can augment medication-assisted ambulatory treatment and support broader recovery/resiliency goals (Substance Abuse and Mental Health Services Administration (SAMHSA), Treatment

- Buprenorphine, naltrexone, and the combination of buprenorphine/naltrexone may be administered in a physician’s office, Intensive Outpatient Program, or Partial Hospital Program as treatment for Opioid Dependence. In this form of medication-assisted treatment, dependence on an opioid is substituted with medically-managed use of buprenorphine, naltrexone, and/or the combination of buprenorphine/naltrexone. Examples of medications used include, but are not limited to the following:
  - Buprenorphine HCl sublingual tablets
  - Buprenorphine HCl with naloxone HCl dehydrate sublingual tablets (Suboxone®)
  - Oral naltrexone
  - Extended-release injectable naltrexone (Vivitrol®)

- Buprenorphine is a partial agonist opiate receptor in a sublingual tablet form used to treat Opioid Dependence and is physician-administered on a daily or less-than-daily basis in three phases (induction, stabilization and maintenance) (U.S. Food and Drug Administration (FDA) New Drug to Treat Opiate Dependence in Doctor’s Office, 2003).

- Suboxone® (buprenorphine-naloxone) is a partial agonist/antagonist opiate receptor in dehydrate sublingual tablet form used to treat Opioid Dependence and can be physician-administered on a daily or less-than-daily basis in three phases (induction, stabilization and maintenance) (FDA, 2003).

- Oral naltrexone is an antagonist opiate blocker in tablet form used to treat Opioid Dependence that can block the effects of opioids for up to 72 hours and is either self-administered and/or provider monitored on a daily basis (FDA, 2003).

- Vivitrol® is an extended-release opiate receptor antagonist injectable form of naltrexone used to treat Opioid Dependence and is provider administered through intramuscular (IM) injection once every 4 weeks, blocking the effects of opioids for up to 30 days (SAMHSA, Injectable Naltrexone, 2010).

- The treating physician must meet training and service requirements, as well as secure a registration number and unique identification number from the Drug Enforcement Agency (DEA) in order to administer buprenorphine (SAMHSA, TIP 40, 2004).

- Naltrexone is not a controlled substance and can be prescribed by any healthcare provider licensed to prescribe medications with no special training. However, providers should closely follow evidence-based best practices when conducting naltrexone therapy (SAMHSA, TIP 49, 2009).

**PART I: BENEFITS**

Before using this guideline, please check enrollee’s specific plan document and any federal or state mandates, if applicable.

**Benefits**

Benefits include the following services:

- Diagnostic evaluation and assessment
- Treatment planning
- Referral services
- Medication management
- Individual, family, therapeutic group and provider-based case management services
- Crisis intervention

**Covered Services**

**Covered Health Service(s) – 2001**

Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

A Covered Health Service is a health care service or supply described in Section 1: What's Covered--Benefits as a Covered Health Service, which is not excluded under Section 2: What's Not Covered--Exclusions.

**Covered Health Service(s) – 2007, 2009 and 2011**

Those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.
- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Certificate of Coverage under Section 1: Covered Health Services and in the Schedule of Benefits.
- Not otherwise excluded in this Certificate of Coverage under Section 2: Exclusions and Limitations.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.
Limitations and Exclusions

The requested service or procedure for the treatment of a mental health condition must be reviewed against the language in the enrollee's benefit document. When the requested service or procedure is limited or excluded from the enrollee’s benefit document, or is otherwise defined differently, it is the terms of the enrollee's benefit document that prevails.


Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:

- Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
- Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered experimental.
- Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practice guidelines as modified from time to time.
- Not clinically appropriate for the member's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

Additional Information

The lack of a specific exclusion that excludes coverage for a service does not imply that the service is covered. The following are examples of services that are inconsistent with the Level of Care Guidelines and Best Practice Guidelines (not an all inclusive list):

- Services that deviate from the indications for coverage summarized in the previous section.
- The provider does not meet training and service requirements, and has not secured a registration number and a unique identification number from the Drug Enforcement Agency (DEA).
- A diagnosis of Opioid Dependence has not been established.
- The treatment plan that has not been modified when there has been partial or no response to an adequate trial of treatment.

PART II: COVERAGE CRITERIA

- Physician Requirements
Physicians must meet one or more of the following training requirements:

- Hold a subspecialty board certification in addiction psychiatry from the American Board of Psychiatry and Neurology;
- Hold an addiction certification from the American Board of Addiction Medicine (ABAM);
- Hold a subspecialty board certification in Addiction Medicine from the American Osteopathic Association (AOA);
- Have completed no less than 8 hours of SAMHSA authorized training for the treatment or management of opioid-dependent patients provided by a SAMHSA approved organization such as the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, or the American Psychiatric Association.

In addition to the above training requirements, physicians must meet both of the following criteria:

- Have the capacity to provide or refer patients for necessary ancillary services such as psychotherapy or recovery support services; AND
- Agree to maintain a caseload consistent with the limits outlined in the Drug Addiction Treatment Act of 2000. There is a 30-patient limit for the first year and 100-patient limit after the provider petitions the DEA for approval (American Society of Addiction Medicine, 3rd Edition, (ASAM), 2013).

Physicians who meet the above requirements must also secure a prescriber registration number from the Drug Enforcement Agency (DEA). Ambulatory treatment with buprenorphine may only be prescribed by certified, waivered physicians. The waiver that allows for ambulatory administration of buprenorphine does not include physician assistants, nurse practitioners, or other non-physicians with prescribing authority in their state (ASAM, 2013).

Naltrexone is not a controlled substance and can be prescribed by any healthcare provider licensed to prescribe medications with no special training. However, providers should closely follow evidence-based best practices when conducting naltrexone therapy.

- The indications for coverage of ambulatory treatment of Opioid Dependence (SAMHSA, TIP 40, 2004):
  - The member has a diagnosis of Opioid Dependence (304.00).
The member has provided informed consent to treatment where informed consent includes the following:

- The member has been informed of safe and effective alternatives and has chosen ambulatory treatment of Opioid Dependence.
- The member understands the potential risks and benefits of treatment.
- The member is willing and able to follow the treatment plan including safety precautions for treatment.

The member has no known contraindications to buprenorphine or naltrexone treatment.

If the member is pregnant:

- Methadone is currently the standard treatment for pregnant women who are addicted to opioids. However, there is evidence that buprenorphine may have lower severity of neonatal abstinence syndrome. The physician may consider buprenorphine treatment as an alternative (American College of Obstetricians and Gynecologists (ACOG), May, 2012).
  - If buprenorphine is prescribed during pregnancy, single agent Buprenorphine sublingual tablets are recommended (ACOG, 2012).

The member does not have a co-occurring dependence on high doses of benzodiazepines or other central nervous system depressants including alcohol.

Co-occurring mental health conditions, if present, are unlikely to undermine the member’s ability to participate in treatment, or don’t otherwise indicate the need for treatment in a higher level of care.

The member history of relapse, if any, doesn’t indicate the need for a higher level of care.

The member doesn’t have a history of poor response to well-conducted episodes of buprenorphine or naltrexone treatment.

The member is not actively or chronically exhibiting suicidal or homicidal ideation or attempts.

**PART III: CLINICAL BEST PRACTICE**

**Evaluation and Treatment Planning**

- An assessment of a member who is suspected of being dependent on opioids should include the following (American Psychiatric Association, Treatment of Substance Use Disorders (APA), 2006):
- Complete psychiatric and medical history;
- Physical examination;
- Mental status examination;
- Relevant laboratory testing; and
- A psychosocial assessment that determines the member's level of motivation, stage of readiness to change, substance use history, family, social and occupational functioning.
- A formal psychiatric assessment.

The findings from the assessment provide the basis for establishing a diagnosis of Opioid Dependence, and help to provider determine the most appropriate treatment (SAMHSA, TIP 43, 2009).

Providers should determine whether an opioid dependent member will benefit most from receiving ambulatory treatment with maintenance phase buprenorphine or whether detoxification/medically supervised withdrawal services are more appropriate. This determination should be made after consideration of the following as part of the standard evaluation:
- The member's pattern of use,
- Treatment history,
- History of relapse,
- The ability of the member to participate in an ambulatory buprenorphine treatment plan,
- Previous treatment with ambulatory opioid medications, and
- Availability of support.

Because providers may offer both ambulatory detoxification/medically supervised withdrawal and ambulatory treatment with buprenorphine services, the clinical assessment should indicate the most appropriate treatment approach for a particular member.

The provider in collaboration with the member must document clear, reasonable and objective treatment goals that stem from the member's diagnosis, and are supported by specific treatment strategies which address the member's symptoms, and take into account the member's preferences and readiness for change. The treatment plan must include objectives, actions and timeframes to address ALL of the following:
- Interventions for monitoring and managing vital signs, withdrawal symptoms, co-occurring medical conditions, and medication precautions, contraindications, and side effects.
o Inventorying the member’s strengths and other psychosocial resilience factors such as the member’s support network;

o Confirming whether the member has an advance directive, a recovery plan, and a plan for managing relapse;

o How symptom reduction and rapid stabilization will be achieved;

o How co-occurring mental health conditions, if any, will be managed;

o How the member’s ability to manage their condition will be improved such as by providing health education, and linking the member with peer services and other community resources such as an age-appropriate organized sobriety support group if clinically indicated including a recommendation for obtaining an accountability partner such as a sponsor or re-connecting with an accountability partner if the member already has one;

o How risk issues related to the member’s presenting condition, co-occurring mental health conditions, or co-occurring medical conditions will be managed including how the member’s motivation will be maintained/enhanced, provision of close supervision of behavior including drug testing, addressing medication effects or possible side effects, and collaborating with the member to develop/revise the advance directive or relapse prevention plan;

o How the member’s family and/or social support network will participate in the member’s treatment with the member’s documented consent when such participation is essential and clinically appropriate;

o How treatment will be coordinated with other providers with the member’s documented consent; AND

o Initially identifying the next appropriate level of care including an anticipated date of discharge and actions to be taken to facilitate the member’s transition.

**Buprenorphine (or Suboxone®) Treatment Protocol**

**Induction Phase (SAMHSA, TIP 40, 2004)**

- Induction is the medically monitored phase of treatment during which the member switches from the opioid of abuse to buprenorphine.

- Buprenorphine is first administered during induction after the member has abstained from using opioids for 12-24 hours, and is in the early stages of opioid withdrawal.

- Induction is typically initiated in the physician’s office as observed therapy, and may be carried out using 4mg, followed by up to 4mg after 4 hours if needed. Day 1 should not exceed 8mg. 4/1mg in 2-4 hours with additional 4/1mg if indicated for buprenorphine-naloxone.
• Induction continues in the physician’s office with daily administration of increasing dosages of buprenorphine until a therapeutic dose is achieved.

• During induction the physician should monitor the member’s response to treatment and continued motivation to participate in comprehensive treatment that includes non-pharmacological interventions alongside buprenorphine treatment.

Stabilization Phase (SAMHSA, TIP 40, 2004)

• During the stabilization phase, the member’s withdrawal symptoms lessen, there are minimal or no side effects, the member’s cravings for the opioid of abuse diminish and non-pharmacological interventions (i.e., therapy, peer support) are introduced as a part of a comprehensive substance use treatment plan (SAMHSA, TIP 40, 2004).

• For most members, the stabilization dosage is 12-16mg per day, although some members may need up to 32mg per day. Increasing the dosage to 24mg or more per day is usually necessary for every-other-day dosing schedules.

• Office visits are less frequent during stabilization, and office-based administration of buprenorphine may be replaced with a prescription for use at home (SAMHSA, TIP 40, 2004).

• Take-Home Medication is only permitted under specific conditions according to SAMHSA regulations to include (SAMHSA, TIP 43, 2009)
  - An absence of recent drug and alcohol abuse;
    - Regular opioid treatment attendance;
    - The absence of significant behavioral problems in treatment;
    - The absence of any recent criminal activity;
    - A stable home environment, family and social support system;
    - An acceptable time in comprehensive maintenance treatment;
    - Assurance of safe storage of medication;
    - Clear indicators that benefits of decreased office visits outweigh risk of medication diversion.
    - Members should continue counseling and other care as needed; and
    - When ready, members should progress to either continued maintenance treatment or tapering of buprenorphine.

• During stabilization the physician should continue to monitor the member’s response to treatment and level of motivation, as well as assess whether the member is taking buprenorphine as prescribed (SAMHSA, TIP 49, 2009).
The dose may need to be adjusted if the member experiences withdrawal symptoms or feels compelled to use opioids (SAMHSA, TIP 40, 2004).

The physician should consider referring the member to a more intensive level of care if the member continues to use opioids, or is unwilling to continue office-based treatment.

Because of the long half-life of buprenorphine it may be possible to switch the member to alternate-day dosing once stabilization has been achieved (SAMHSA, TIP 40, 2004).

**Maintenance Phase**

- The Maintenance phase of treatment is characterized by the member taking a stable dose of buprenorphine and working with a physician or therapist to address non-pharmacological substance use issues as part of a comprehensive substance use treatment plan (SAMHSA, TIP 43, 2009).
- The maintenance phase begins when the member no longer experiences withdrawal, has no side effects and no longer has uncontrollable cravings for opioids (SAMHSA, TIP 43, 2009).
- The frequency of office visits during the maintenance phase is further reduced, and if indicated, the member continues to self-administer buprenorphine (SAMHSA, TIP 43, 2009).
- During the maintenance phase the physician should continue to monitor the member’s response to treatment, level of motivation as well as assess whether the member is taking buprenorphine as prescribed (SAMHSA, TIP 43, 2009).
- The duration of the maintenance phase depends on the severity and complexity of the member’s condition as well as the member’s response to treatment and stage of readiness to change (SAMHSA, TIP 43, 2009). The indications for discontinuing maintenance treatment are:
  - The member has achieved the goals outlined in the treatment plan, medically-monitored withdrawal from buprenorphine has been completed, and an adequate discharge plan has been developed with the member which includes the following (SAMHSA, TIP 43, 2009):
    - The plan for service at the next level of care;
    - Linkages with community resources; and
    - Confirmation that the member was provided with written instruction for what to do in the event that a crisis arises prior to the first post-discharge appointment.
  - The need for a higher level of behavioral health care is suggested such as when:
- The member’s response to treatment has been poor despite alterations in the treatment plan (SAMHSA, TIP 43, 2009);
- The member’s stage of readiness has not improved despite motivational enhancement and is likely to undermine office-based treatment (SAMHSA, TIP 43, 2009);
- A co-occurring mental health or medical condition has worsened and is likely to undermine office-based treatment (SAMHSA, TIP 43, 2009).
  - The member otherwise makes an informed decision to discontinue treatment (SAMHSA, TIP 43, 2009).
  - If discontinuation is indicated, tapering should occur over a 2-3 week period. If significant withdrawal symptoms emerge, dosage should be split into 2-3 smaller dosages per day until buprenorphine can be safely discontinued (SAMHSA, TIP 43, 2009).

Oral Naltrexone Treatment Protocol (SAMHSA, TIP 49, 2009)

- Oral naltrexone is most effective for members who are highly motivated or have a clear monitoring plan (i.e., provider or family members agree to observe daily dosing).
- A complete detoxification from opioids must be completed at least 7-10 days prior to naltrexone therapy and the physical exam should include a toxicological screening in addition to the following:
  - Members must be medically cleared to receive naltrexone (e.g., normal liver functioning tests, negative toxicology screenings, negative pregnancy screening);
  - Members should not be using opioids currently or have evidence of recent use, including methadone or buprenorphine maintenance;
  - Members should not be anticipating surgery or have chronic pain for which opioids may be required in the future;
  - Members should not have severe liver or kidney disease;
  - Members should be highly motivated to abstain from opioids; and
  - Members should be willing to participate in psychosocial substance use treatment.
- Initial oral naltrexone dosage for most members is 50mg/day in a single tablet. For members with high risk factors (e.g., women, younger members, members with shorter abstinence) 12.5mg/day should be given for 1 week, with gradual weekly increases up to 50mg/day.
• The average oral maintenance daily dose remains 50mg/day for up to 3 months although this should be tailored for individual members and oral maintenance may last up to 1 year.

• Discontinuation of oral naltrexone is not associated with withdrawal syndrome and it is not necessary to taper the dose however providers should remind members that they should not take opioid medications for at least 3 days following discontinuation and they may be generally more sensitive to opioid medications.


• The extended-release formulation of naltrexone for the treatment of Opioid Dependence was FDA approved in 2010 and is considered a good alternative to daily oral naltrexone for members who have not responded to other pharmacological and/or non-pharmacological forms of treatment and are challenged by daily oral naltrexone adherence.

• A complete detoxification from opioids must be completed at least 7-10 days prior to naltrexone therapy and a physical exam should include a toxicological screening. In addition:
  o Members must be medically cleared to receive naltrexone (e.g., normal liver function tests, negative toxicology screenings, negative pregnancy testing);
  o Members should not be using opioids currently or have evidence of recent use;
  o Members should not be anticipating surgery or have chronic pain for which opioids may be required in the future;
  o Members should not have severe liver or kidney disease;
  o Members should not have a bleeding disorder or obesity, preventing deep IM injections;
  o Members should be motivated to abstain from opioids; and
  o Members should be willing to participate in psychosocial substance use treatment.

• Injectable naltrexone is most effective when part of a management program that includes peer support services, participation in an organized sobriety support group, an accountability partner or other community support.

• Injectable naltrexone is administered by intramuscular (IM) gluteal injection once per month or every 4 weeks by a medical professional. If a dose is delayed or missed, the next injection should be administered as soon as possible.
• It is not recommended that an injection be readministered earlier than 4 weeks or at a higher dose than 380mg.

• There is no clearly defined duration of treatment with IM naltrexone however providers may consider discontinuation once a member has achieved stable abstinence from opioids, has a sound support and recovery plan and there is a reduced risk for relapse.

• Members discontinuing IM naltrexone should be reminded that they should not take any opioid medications for at least 30 days due to increased risk of experiencing opioid side effects and overdose.

**Non-Pharmacological Treatment Interventions**

Pharmacotherapy alone is rarely a sufficient treatment for Opioid Dependence and psychosocial interventions are necessary for most members (SAMHSA, TIP 49, 2009). These interventions may vary according to the member’s needs and if indicated these services may include:

• Individual or group participation in Motivational Enhancement, Cognitive, Behavioral and other therapies as indicated (SAMHSA, TIP 49, 2009);

• Coordination of a multidisciplinary team representing psychosocial or medical services as indicated (SAMHSA, TIP 49, 2009);

• Psychoeducation, including health education services (SAMHSA, TIP 49, 2009).

• Oversight and facilitation of access to appropriate treatment, including medication for other medical and behavioral health conditions as needed (SAMHSA, TIP 49, 2009).

• Linking the member with peer services and other community resources when clinically indicated. These resources may include an age-appropriate organized sobriety support group, and an accountability partner (SAMHSA, TIP 49, 2009).

• Physicians providing buprenorphine treatment should ensure that they are capable of providing psychosocial services, either in their own practice or through referrals to behavioral health practitioners in the community in accordance with DATA 2000 (SAMHSA, TIP 40, 2009).

**Managing Relapse**

• The provider should have a plan in place as to how he/she will respond to member relapse. The following should be considered:
  
  o A relapse indicates a reduction in overall stability of the member and may require an adjustment to the treatment plan or level of care (SAMHSA, TIP 43, 2009);
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- A reassessment of the intensity and effectiveness of psychosocial interventions may be needed, and if not currently in place, the need to introduce interventions (SAMHSA, TIP 43, 2009);
- Beginning or increasing urine screening appointments (SAMHSA, TIP 43, 2009);
- Ensuring that medical and behavioral conditions are stable (SAMHSA, TIP 43, 2009); and
- Consider referrals for detoxification in addition to motivational enhancement and additional psychosocial interventions (SAMHSA, TIP 43, 2009).

Management of Recovery and Co-Occurring Mental Health Conditions

- Pharmacotherapy alone may not be sufficient to support recovery, and is unlikely to provide a comprehensive enough treatment plan for members with co-occurring mental health conditions (SAMHSA, TIP 40, 2004).
- The provider and member should collaborate to devise a treatment plan which incorporates psychosocial interventions that support recovery and, where applicable, address treatment of co-occurring mental health conditions (SAMHSA, TIP 40, 2004).

PART IV: DEFINITIONS

**Agonist** A drug or medication that can interact with nerve cell receptors to stimulate drug actions or effects.

**Antagonist** A drug or medication that prevents molecules of other drugs/medications from binding to a receptor (e.g., an opioid receptor). Antagonists can also displace other opioids and can precipitate withdrawal, or block the effects of other opioids. Examples of antagonists include naltrexone and naloxone.

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

**Full Opioid Agonist** A drug or medication that stimulates activity at opioid receptors in the brain that are normally stimulated by naturally occurring opioids and endorphins. Examples of full opioid agonists include morphine, methadone, oxycodone, hydrocodone, heroin, codeine, meperidine (Demerol®), propoxyphene, and fentanyl.

**Induction** The medically monitored phase of treatment during which the member switches from the opioid of abuse to buprenorphine.
**Maintenance** The phase of treatment when the person is taking a stable dose and working with a physician or counselor to address other issues affecting his/her dependence and ability to rebuild his/her life.

**Office-Based Treatment of Opioid Dependence** A form of replacement therapy that is administered in a physician’s office where dependence on an opioid is substituted with use of either of two forms of buprenorphine currently approved for this type of use:

- Buprenorphine HCl sublingual tablets
- Buprenorphine HCl with naloxone HCl dehydrate sublingual tablets (Suboxone®).
- Oral naltrexone
- Extended-release injectable naltrexone (Vivitrol®)

**Opioid Dependence** According to the DSM, Opioid Dependence is a form of substance use disorder whose essential features are signs and symptoms that reflect compulsive, prolonged self-administration of opioid substances that are used for no legitimate medical purpose or, if a general medical condition is present that requires opioid treatment, that are used in doses that are generally in excess of the amount needed for pain relief.

**Partial Opioid Agonist** A drug or medication that can both activate and block opioid receptors, depending on the clinical situation. Under appropriate conditions, partial agonists can produce effects similar to those of either agonists or antagonists. Buprenorphine is a partial opioid agonist.

**REFERENCES**


**CODING**

The Current Procedural Terminology (CPT) codes and HCPCS codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

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<td>90792</td>
<td>Psychiatric diagnostic interview examination: Evaluation and Treatment Planning</td>
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<tr>
<td>99245</td>
<td>Induction</td>
</tr>
<tr>
<td>99213</td>
<td>Stabilization Phase Medication Management</td>
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<td>99213 + 90833</td>
<td>Stabilization Phase Individual Therapy with Medication Management</td>
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<tr>
<td>99213 + 99836</td>
<td>Stabilization Phase Individual Therapy with Medication Management (when clinically indicated &gt;45 minutes).</td>
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<td>99213</td>
<td>Maintenance Phase Medication Management</td>
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<tr>
<td>96372</td>
<td>Maintenance Phase Medication Management (Injectable Naltrexone when clinically indicated)</td>
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**Limited to specific diagnosis codes?**

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<td>305.50; 304.00; 304.00</td>
<td>Opioid Use Disorder (mild, moderate, severe)</td>
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<td>Opioid Intoxication</td>
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**Limited to place of service (POS)?**

- X YES  □ NO

- Outpatient

**Limited to specific provider type?**

- □ YES  X NO

**Limited to specific revenue codes?**

- □ YES  X NO

**HISTORY**

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<td>10/2014</td>
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The enrollee’s specific benefit documents supersede these guidelines and are used to make coverage determinations. These Coverage Determination Guidelines are believed to be current as of the date noted.