# MEDICAL POLICY – 3.01.520

**Opioid Antagonists Under Heavy Sedation or General Anesthesia as a Technique of Opioid Detoxification**

<table>
<thead>
<tr>
<th>Effective Date:</th>
<th>April 1, 2017</th>
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<tbody>
<tr>
<td>Last Revised:</td>
<td>Oct. 24, 2017</td>
</tr>
<tr>
<td>Replaces:</td>
<td>3.01.02</td>
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</tbody>
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**RELATED MEDICAL POLICIES/GUIDELINES:**
- 2.04.513 Drug Testing in Pain Management and Substance Abuse Treatment Settings
- 3.01.515 Behavioral Health: Residential/Sub-Acute Detoxification

Select a hyperlink below to be directed to that section.

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- CODING
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- EVIDENCE REVIEW
- REFERENCES
- HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

## Introduction

For substance use disorders, detoxification — commonly called detox — is the process in which the body breaks down and then eliminates the drug(s). Sometimes, however, withdrawing from a substance can cause extremely uncomfortable physical symptoms. Medical detoxification helps a person through severe withdrawal with the use of medications, under the care and monitoring of a medical professional. One method of withdrawal from opioid drugs is called ultra-rapid detoxification. It calls for the patient to be placed under anesthesia and then given high doses of a drug that blocks the opioid. The anesthesia prevents the patient from experiencing discomfort or having a memory of the symptoms of acute withdrawal. Ultra-rapid detoxification is considered unproven (investigational). There are few medical studies comparing this approach to standard detox approaches. Experience with ultra-rapid detoxification has shown that it can lead to life-threatening events.

**Note:** The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.
Policy Coverage Criteria

<table>
<thead>
<tr>
<th>Technique</th>
<th>Investigational</th>
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<td>Opioid detoxification</td>
<td>Opioid antagonists under heavy sedation or anesthesia are considered investigational as a technique for opioid detoxification (ie, ultra-rapid detoxification).</td>
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Additional Information

Specialized facilities that offer ultra-rapid detoxification include but are not limited to:

- Center for Research and Treatment of Addiction (CITA)
- Neuraad™ Treatment Centers
- Nutmeg Intensive Rehabilitation Centers

Coding

N/A

Related Information

Benefit Application

Opioid dependence is considered a mental disorder, thus claims for ultra-rapid detoxification may be adjudicated under the mental health benefits.

Evidence Review
Description

The use of relatively high doses of opioid antagonists under deep sedation or general anesthesia is a technique for opioid detoxification and is known as ultra-rapid detoxification. It is a potential alternative to standard detoxification that allows patients to avoid the acute symptoms associated with initial detoxification. Ultra-rapid detoxification is used in conjunction with maintenance treatments, eg, oral opioid antagonists and psychosocial support.

Background

The traditional treatment of opioid addiction involves substituting the opiate (i.e., heroin) with an equivalent dose of a longer-acting opioid antagonist, (ie, methadone) followed by tapering to a maintenance dose. Methadone maintenance therapy does not resolve opioid addiction but has been shown to result in improved general health, retention of patients in treatment, and a decrease in the risk of transmitting human immunodeficiency virus (HIV) or hepatitis. However, critics of methadone maintenance point out that this strategy substitutes one drug of dependence for the indefinite use of another. Detoxification followed by abstinence is another treatment option, which can be used as the initial treatment of opioid addiction or offered as a final treatment strategy for patients on methadone maintenance. Detoxification is associated with acute symptoms followed by a longer period of protracted symptoms (ie, 6 months) of withdrawal. Although typically not life-threatening, acute detoxification symptoms include irritability, anxiety, apprehension, muscular and abdominal pains, chills, nausea, diarrhea, yawning, lacrimation, sweating, sneezing, rhinorrhea, general weakness, and insomnia. Protracted withdrawal symptoms include a general feeling of reduced well-being and drug craving. Relapse is common during this period.

Detoxification may be initiated with tapering doses of methadone or buprenorphine (an opioid agonist-antagonist), treatment with a combination of buprenorphine and naloxone (an opioid antagonist), or discontinuation of opioids and administration of oral clonidine and other medications to relieve acute symptoms. However, no matter what type of patient support and oral medications are offered, detoxification is associated with patient discomfort, and many patients may be unwilling to attempt detoxification. In addition, detoxification is only the first stage of treatment. Without ongoing medication and psychosocial support after detoxification, the probability is low that any detoxification procedure alone will result in lasting abstinence. Opioid antagonists, such as naltrexone, may also be used as maintenance therapy to reduce drug craving and thus reduce the risk of relapse.
Dissatisfaction with current approaches to detoxification has led to interest in using relatively high doses of opioid antagonists, such as naltrexone, naloxone, or nalmefene under deep sedation with benzodiazepine or general anesthesia. This strategy has been referred to as “ultra-rapid,” “anesthesia-assisted,” “one-day assisted” or “one-day” detoxification. The use of opioid antagonists accelerates the acute phase of detoxification, which can be completed within 24 to 48 hours. Because the patient is under anesthesia, he or she has no discomfort or memory of the symptoms of acute withdrawal. Various other drugs are also administered to control acute withdrawal symptoms, such as clonidine (to attenuate sympathetic and hemodynamic effects of withdrawal), ondansetron (to control nausea and vomiting), and somatostatin (to control diarrhea). Hospital admission is required if general anesthesia is used. If heavy sedation is used, the program can potentially be offered on an outpatient basis. Initial detoxification is then followed by ongoing support for the protracted symptoms of withdrawal. In addition, naltrexone may be continued to discourage relapse.

Ultra-rapid detoxification may be offered by specialized facilities. These programs typically consist of three phases: a comprehensive evaluation, inpatient detoxification under anesthesia, and finally, mandatory post-detoxification care and follow-up. The program may be offered to patients addicted to opioid or narcotic drugs such as opium, heroin, methadone, morphine, meperidine, hydromorphone, fentanyl, oxycodone, hydrocodone, or butorphanol. Once acute detoxification is complete, the opioid antagonist naltrexone is often continued to decrease drug craving, with the hope of reducing the incidence of relapse.

**Summary of Evidence**

Ultra-rapid detoxification is an opioid detoxification technique that uses relatively high doses of opioid antagonists under deep sedation or general anesthesia. The paucity of controlled trials and lack of a standardized approach to ultra-rapid detoxification does not permit scientific conclusions regarding the safety or efficacy of ultra-rapid detoxification compared with other approaches that do not involve deep sedation or general anesthesia. Moreover, there are concerns about adverse effects, including life-threatening or potentially life-threatening events. Thus, this technology is considered investigational.

**Ongoing and Unpublished Clinical Trials**

A search of ClinicalTrials.gov in February 2017 did not identify and ongoing or unpublished trials that would likely influence this review.
Practice Guidelines and Position Statements

**National Institute for Health and Clinical Excellence (NICE)**

In 2007, the NICE issued clinical practice guidelines on “drug misuse, opioid detoxification.”(11) The guidelines include the following statement regarding ultra-rapid detoxification, “Ultra-rapid detoxification under general anesthesia or heavy sedation (where the airway needs to be supported) must not be offered. This is because of the risk of serious adverse events, including death.”

**American Psychiatric Association (APA)**

In 2007, the APA Work Group on Substance Use Disorders released a practice guideline for the treatment of patients with substance use disorders.(12) The practice guideline included the following recommendation: “Anesthesia-assisted rapid opioid detoxification is not recommended because of lack of proven efficacy and adverse risk-benefit ratios.”

**American Society of Addiction Medicine (ASAM)**

In 2005, the ASAM published a public policy statement regarding opiate detoxification under sedation or anesthesia.(12) It included the following position statements:

Opioid detoxification alone is not a treatment of opioid addiction. ASAM does not support the initiation of acute opioid detoxification interventions unless they are part of an integrated continuum of services that promote ongoing recovery from addiction.

Ultra-Rapid 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.

Although there is medical literature describing various techniques of Rapid Opioid Detoxification (ROD), further research into the physiology and consequences of ROD should be supported so that patients may be directed to the most effective treatment methods and practices.
U.S. Preventive Services Task Force Recommendations

No U.S. Preventive Services Task Force recommendations for opioid detoxification under heavy sedation or general anesthesia have been identified.

Medicare National Coverage

Medicare Policy on this issue is as follows:

Section 130.7, of the Medicare Coverage Issues Manual (Medical Procedures), Withdrawal Treatment for Narcotic Addictions, states:

Withdrawal is an accepted treatment for narcotic addiction, and Part B payment can be made for these services if they are provided by the physician directly or under his personal supervision and if they are reasonable and necessary. In reviewing claims, reasonableness and necessity are determined with the aid of the B/Medicare Administrative Contractor’s medical staff.

Drugs that the physician provides in connection with this treatment are also covered if they cannot be self-administered and meet all other statutory requirements.

Cross-reference:


Section 130.6, Treatment of Drug Abuse (Chemical Dependency), states:

The Centers for Medicare & Medicaid Services recognizes that there are similarities between the approach to treatment of drug abuse and alcohol detoxification and rehabilitation. However, the intensity and duration of treatment for drug abuse may vary (depending on the particular substance(s) of abuse, duration of use, and the patient’s medical and emotional condition) from the duration of treatment or intensity needed to treat alcoholism. Accordingly, when it is medically necessary for a patient to receive detoxification and/or rehabilitation for drug substance abuse as a hospital inpatient, coverage for care in that setting is available. Coverage is also available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. (See the Medicare
Benefit Policy Manual (BPM), Chapter 6, “Hospital Services Covered Under Part B,” §§20.) The services must also be reasonable and necessary for treatment of the individual’s condition. (See the Medicare BPM, Chapter 16, “General Exclusions from Coverage,” §90.) Decisions regarding reasonableness and necessity of treatment, the need for an inpatient hospital level of care and length of treatment, should be made by A/B Medicare Administrative Contractors (MACs) based on accepted medical practice with the advice of their medical consultant. (In hospitals under Quality Improvement Organization (QIO) review, QIO determinations of medical necessity of services and appropriateness of the level of care at which services are provided are binding on A/B MACs for purposes of adjudicating claims for payment.)

Regulatory Status

In October 2002, Reckitt Benckiser received U.S. Food and Drug Administration (FDA) approval to market the following for use in opioid addiction treatment:

- Subutex®, a buprenorphine monotherapy product
- Suboxone®, a buprenorphine/naloxone combination product

References


History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
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<tr>
<td>04/12/16</td>
<td>New Policy. Replaces 3.01.02 which is archived. Coverage statements remain unchanged.</td>
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<tr>
<td>04/01/17</td>
<td>Annual Review, approved March 14, 2017. No changes made to policy.</td>
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<tr>
<td>10/24/17</td>
<td>Policy moved to new format, no changes to policy statement.</td>
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Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
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  - Information written in other languages

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Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at

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