Corporate Medical Policy

Rapid Opioid Detoxification

File Name: rapid_opioid_detoxification
Origination: 3/2009
Last CAP Review: 7/2011
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Description of Procedure or Service

The use of relatively high doses of opioid antagonists under deep sedation or general anesthesia is a technizue 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 e.g., oral opioid antagonists and psychosocial support.

The traditional treatment of opioid addiction involves substituting the opiate, such as heroin, with an equivalent dose of a longer acting opioid antagonist, i.e., methadone, followed by tapering to a maintenance dose. Methadone maintenance therapy does not resolve opioid addition but has been shown to result in improved general health, retention of patients in treatment, and a decrease in the risk of transmitting 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 addition, or offered as a final treatment strategy for patients on methadone maintenance. Detoxification is associated with acute symptoms followed by longer periods of protracted symptoms (i.e., 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 buprenophrine (an opioid agonist-antagonist), treatment with a combination of buprenophrine 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 naloxone under deep sedation with benzodiazepine or general anesthesia. This strategy has been referred to as "ultra-rapid," "anesthesia assisted," "accelerated" or "one-day" detoxification. The use of opioid antagonists accelerated the acute phase of detoxification, which can be completed within 24-48 hours. Since the patient is under anesthesia, the patient 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. Neuraad™ Treatment Centers, Nutmeg Intensive Rehabilitations, The Coleman Institute, and Center for Research and Treatment of Addiction (CITA) are examples. These programs typically consist of 3 phases: a comprehensive evaluation, inpatient detoxification under anesthesia or outpatient detoxification under sedation, 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, demerol, dilaudid, 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.

Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.

Policy

Rapid Opioid Detoxification is considered investigational. BCBSNC does not provide coverage for investigational services or procedures.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Refer to the individual certificate for prior review requirements.

When rapid opioid detoxification is covered

Not applicable.

When rapid opioid detoxification is not covered

Opioid antagonists under heavy sedation or anesthesia are considered **investigational** as a technique for opioid detoxification (i.e., ultra-rapid detoxification).

Policy Guidelines

The major safety considerations regarding ultra-rapid detoxification are the risks associated with general anesthesia in combination with opioid antagonists. While patients are generally intubated and ventilated, eliminating the risk of choking, intravenous naloxone has been associated with cardiovascular complications such as cardiac arrest and pulmonary edema. These potential safety issues are particularly important, since opioid withdrawal itself is not associated with life-threatening complications. In contrast, advocates of ultra-rapid detoxification point out that detoxification is a painful procedure, and that the risk of anesthesia has generally been considered acceptable when used to relieve pain.

A variety of adverse events has been reported in small numbers of patients, including vomiting while under anesthesia or sedation, various cardiac rhythmic disturbances, pulmonary dysfunction, and renal insufficiency. Vomiting under sedation is particularly worrisome due to the threat of aspiration. Techniques reported to minimize this risk include intubation, use of prophylactic antibiotics, and the use of medication to diminish the volume of gastric secretions. Several deaths occurring either during anesthesia or immediately afterward have been reported. Also, deaths subsequent to ultra-rapid detoxification have been reported. Of particular concern is the fact that the use of opioid antagonists

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results in loss of tolerance to opioids, rendering patients susceptible to overdose if they return to pre-detoxification dosage of illicit drugs.

In summary, the lack of controlled trials and of a standardized approach to ultra-rapid detoxification does not permit scientific conclusions regarding the safety or efficacy of ultra-rapid detoxification compared to other approaches that do not involve deep sedation or general anesthesia. Given the insufficient evidence to evaluate the impact on net health outcomes, this treatment is considered investigational.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: *No specific CPT or HSPCS codes for this service.*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual [Electronic Version]. 3.01.02, 3/13/08

Favrat B, Zimmerman G, Zullino D, et al. Opioid antagonist detoxification under anaesthesia versus traditional clonidine detoxification combined with an additional week of psychosocial support: a randomized clinical trial. *Drug Alcohol Depend* 2006; 81(2):109-16.

Specialty Matched Consultant Review 1/2009

Senior Medical Director Review 2/2009

National Institute for Health and Clinical Evidence. Drug misuse, opioid detoxification. NICE Clinical Guideline 52. Retrieved 8/12/10 from: http://www.nice.org.uk/Gruidance/CG52

BCBSA Medical Policy Reference Manual [Electronic Version]. 3.01.02, 3/12/09

BCBSA Medical Policy Reference Manual [Electronic Version]. 3.01.02, 12/9/2010

Policy Implementation/Update Information

3/2/09 New policy adopted from the BCBS Association. Specialty Matched Consultant Review 1/20/ 2009. Reviewed with Senior Medical Director 2/2/09. Rapid Opioid Detoxification is considered **investigational** for all indications. BCBSNC does not cover investigational services. Notice given 3/2/2009. Policy effective 6/8/2009. (btw)

6/22/10 Policy Number(s) removed (amw)

10/26/10 Policy statement reworded to read: Rapid opioid detoxification is considered investigational. BCBSNC does not provide coverage for investigational services or procedures. Statement under the When It Is Not Covered section was reworded to read: Opioid antagonists under heavy sedation or anesthesia are considered **investigational** as a technique for opioid detoxification (i.e., ultra-rapid detoxification). Rationale in the Policy Guidelines section was updated. Updated references. Specialty Matched Consultant Advisory Panel review 9/30/10. Policy accepted as written. (adn)

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8/16/11 Specialty Matched Consultant Advisory Panel review 7/27/11. No change to policy. (adn)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.