



MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
06/01/2012	07/15/2017	06/28/2016
Policy Name		Policy Number
Acute In-Patient Detoxification (Opioid) PA Criteria		MM-0019
Policy Type		
<input checked="" type="checkbox"/> Medical	<input type="checkbox"/> Administrative	<input type="checkbox"/> Payment

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A. SUBJECT

Acute In-Patient Detoxification (Opioid) Prior Authorization Criteria

B. BACKGROUND

Opioid Use Disorder is a major public health concern leading to extensive morbidity and mortality. It is often a treatment-resistant and chronic condition. Effective treatment requires motivation and adherence to a comprehensive addiction management program. Such a program should involve well-coordinated care between the inpatient environment when appropriate, and the various modalities in the outpatient setting (residential, intensive outpatient, and office-based treatment). Even with intensive treatment options yearly relapse rates remain well over 70%.

C. DEFINITIONS

- **Opioids** are naturally-occurring and synthesized drugs with indications for moderate to severe pain. Additional uses include relief of cough and diarrhea. There are also nonprescription, illicit forms of opioids such as heroin. Due to their potential to be abused and diverted, these are controlled substances under the Drug Enforcement Administration.
- **Detoxification** is the controlled and medically-supervised withdrawal from a drug of addiction in order to minimize severe symptoms. Opioids have the potential to cause dependence; however they are not known to cause a life-threatening withdrawal due to physiologic dependence. In some instances, a medically-precipitated withdrawal in the presence of a co-occurring chronic medical or behavioral health condition has the potential to be life-threatening.



D. POLICY

All admissions that are not screened through a CareSource representative to receive a **Prior Authorization** within 24 hours of admission will be retroactively reviewed to ensure they meet admission guidelines for Acute Inpatient Opioid detoxification treatment.

- I. Opiate withdrawal is often accomplished on an outpatient basis. CareSource will approve the use of acute inpatient opiate detoxification treatment as medically necessary when essential criteria have been met. Authorization of inpatient detoxification for a diagnosis of opioid use disorder will include a review of documentation showing that **1 or more** of the following is present, including how it interferes with opioid use disorder detoxification at a lower level of care:
 - A. The member has a medical condition that clearly warrants acute inpatient detoxification (e.g. uncontrolled diabetes)
 - B. The member has a co-occurring substance use disorder with potential for life-threatening withdrawal (e.g. alcohol use disorder), which is also active at the time of admission
 - C. The member has a co-occurring psychiatric disorder, which is unstable or complicated by threats to self or others, or causes member to be unable to care for basic needs
 - D. The member's home or community environment is not supportive of outpatient detoxification (e.g. homeless or has other individuals actively using at member's residence)
 - E. The member has sustained/reported an accidental overdose leading to a life-threatening event and medical intervention
 - F. The member has severely complicated opioid withdrawal symptoms (i.e. moderate to severe withdrawal) that require around-the-clock care as manifested by **ALL** of the following:
 1. Vomiting or diarrhea due to opioid withdrawal
 2. Marked dehydration or electrolyte abnormality that cannot be corrected (to near normal) in an emergency department or other ambulatory setting (e.g., serum potassium less than 2.5 mEq/L (mmol/L), serum sodium less than 130 mEq/L (mmol/L))
 - G. Acute toxicity or instability from substance use requiring inpatient care (e.g., hallucinations in the absence of delirium) is present for which treatment at lower level of care (e.g., emergency department, observation care) is not feasible or is inappropriate (e.g., less intensive level is unavailable or not suitable to patient condition or treatment history).
 - H. Other inpatient medical or psychiatric care is needed due to risk or comorbidity as indicated by **ALL** of the following:
 1. Treatment is needed because of patient risk due to **1 or more** of the following
 - 1.1 Imminent danger to self-due to **1 or more** of the following:
 - a. Imminent risk for recurrence of suicide attempt or act of serious harm to self as indicated by **ALL** of the following:
 - (1) Very recent suicide attempt or deliberate act of serious harm to self
 - (2) There has not been sufficient relief of factors that precipitated attempt or act.
 - b. Current plan for suicide or serious harm to self
 - c. Command auditory hallucinations for suicide or serious harm to self
 - d. Patient has persistent thoughts of suicide or serious harm to self that cannot be adequately monitored at lower level of care due to **1 or more** of the following:
 - (1) Insufficient behavioral care available to meet patient needs (such as required provider or lower level facility not available)
 - (2) Patient characteristics such as high impulsivity or unreliability



- (3) Environment does not support recovery.
- (4) Ready access to lethal means
- 1.2 Imminent danger to others due to **1 or more** of the following:
 - a. Imminent risk for recurrence of attempt to seriously harm another as indicated by **ALL** of the following:
 - (1) Very recent attempt to seriously harm another
 - (2) There has not been sufficient relief of factors that precipitated attempt or act
 - b. Current plan for homicide or serious harm to another
 - c. Command auditory hallucinations or paranoid delusions contributing to risk for homicide or serious harm to another
 - d. Patient has persistent thoughts of homicide or serious harm to another that cannot be adequately monitored at lower level of care because of **1 or more** of the following:
 - (1) Insufficient behavioral care available to meet patient needs (e.g., required provider or lower level facility not available)
 - (2) High impulsivity or unreliability
 - (3) Environment does not support recovery
 - (4) Ready access to lethal means
- 1.3 Severe dysfunction in daily living related to substance use disorder as indicated by **1 or more** of the following:
 - a. Extreme deterioration in social interactions (e.g., threatening behaviors with little or no provocation)
 - b. Complete withdrawal from all social interactions
 - c. Complete neglect of self-care with associated impairment in physical status
 - d. Extreme disruption in vegetative function (e.g., life-sustaining functions such as eating)
 - e. Complete inability to maintain any appropriate aspect of personal responsibility in any adult roles (e.g., occupational, parental)
- 1.4 Other severe emotional, behavioral, or cognitive symptoms which preclude ability to engage in recovery without 24-hour monitoring and treatment
- 1.5 Patient requires monitoring due to substance use in combination with medical, psychiatric, or environmental factors that prevent adequate management at lower level of care as indicated by **ALL** of the following:
 - a. Significant substance use effects, medical conditions, or psychiatric comorbidities as indicated by **1 or more** of the following:
 - (1) Substance toxicity or withdrawal requiring medical monitoring
 - (2) Severe emotional, behavioral, or cognitive symptoms which limit or preclude ability to engage in treatment
 - b. Conditions, barriers, or environmental factors preventing treatment at lower level of care as indicated by **1 or more** of the following:
 - (1) Psychiatric comorbidity or opposition to treatment requires 24-hour setting to ensure adherence with medical treatment or adequate motivating interventions
 - (2) Severe behavioral problems (e.g., escalating relapse behaviors, acute psychiatric or substance use crisis, inability to recognize signs and symptoms of relapse) require 24-hour setting for relapse prevention.
 - (3) Living environment outside of 24-hour setting is inadequate to meet patient needs (e.g., lacking resources necessary to support recovery).
- 2. Treatment situation and needs are appropriate for inpatient level (instead of using



lower level of care) as indicated by **1 or more** of the following:

- 2.1 Patient is unwilling to participate voluntarily and requires treatment (e.g., legal commitment) in involuntary unit.
 - 2.2 Voluntary treatment at lower level is not feasible (e.g., lower level care unavailable or inappropriate for patient condition).
 - 2.3 Physical restraint, seclusion, or other involuntary control is needed (e.g., actively violent patient for whom treatment in involuntary unit is deemed necessary in accord with applicable medical and legal criteria).
 - 2.4 Around-the-clock medical or nursing care to address symptoms and initiate interventions is required; specific need is identified.
- I. There is clear medical necessity for inpatient opioid detoxification treatment and substantial justification as to why alternative levels of care are inappropriate (e.g. treatment with buprenorphine, buprenorphine/naltrexone in an outpatient setting)
 - J. The member must demonstrate clear motivation for rapid detoxification from opioid substances without subsequent further usage. Rapid detoxification in a chronic opioid user as an isolated acute treatment has a low likelihood of sustained abstinence in such situations. To assess "readiness for change" an assessment could include standardized scales such as URICA, SOCRATES, or Readiness to Change Scales specific to opiate dependency that assess "readiness for change."
 - K. If a member has had a previous admission for inpatient detoxification within the past 365 days, there is documentation that the member had demonstrated success (e.g. kept appointments, had negative urine drug screens) from the prior detoxification before current relapse.

The inpatient detoxification program has a written Affiliation Agreement so that members are connected/ensured access to outpatient care in timely manner upon discharge due to the high relapse rates from detoxification alone. There are policies and procedures in place to monitor its affiliations.

II. Some state-specific considerations:

A. Ohio

Program must be certified by the Ohio Dept. of Mental Health & Addiction Services. Since detoxification is not by itself treatment, but part of a comprehensive approach to the continuum care needed for evidence-based substance use disorder treatment, the inpatient program shall have a clearly-documented affiliation agreement with at least one alcohol and drug addiction services treatment program certified by the state of Ohio to ensure member access to outpatient care in a timely manner (e.g. IOP program, residential program, sober housing, or outpatient treatment).

B. Kentucky

Program must be licensed by the Kentucky Cabinet for Health Services. The facility shall have written affiliation with other licensed alcohol and drug services available in the community such as: chemical dependency treatment services and services licensed under 902 KAR Chapter 3 including situation, identification, and disposition (SID) units, thirty (30) day residential units, halfway houses and outpatient services. Requires ventilation, crash cart, oxygen and suction are available in the program.

For Medicare Plan members, reference the below link to search for Applicable National Coverage Descriptions (NCD) and Local Coverage Descriptions (LCD):

If there is no NCD or LCD present, reference the CareSource Policy for coverage.



CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 06/01/2012
Date Reviewed: 06/01/2012, 7/01/2013, 7/01/2014, 07/15/2015, 06/xx/2016
Date Revised: 07/01/2013, 07/01/2014
07/15/2015 – Add definitions, revision to criteria regarding criteria, affiliation agreement, State OAC and KAR considerations

G. REFERENCES

1. Suboxone [package insert]. Richmond, VA,: Reckitt Benckiser Pharmaceuticals Inc.; April 2014
2. Subutex [package insert]. Richmond, VA,: Reckitt Benckiser Pharmaceuticals Inc.; April 2014
3. Drugs. 2009; 69 (5):577-607.
4. McConaughy, E.N., Prochaska, J.O., & Velicer, W.F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. Psychotherapy: Theory, Research and Practice, 20, 368-375.
5. Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors* 10, 81-89.
6. National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. This article describes research presented at the American Psychiatric Association 2010 Annual Meeting. Symposium 36, presentation 4. Presented May 23, 2010. New Orleans, Louisiana.
7. International Psychopharmacology Algorithm Project, Opioid Algorithm (2013 update).
8. 902 KAR 20:111. Medical detoxification services
9. OAC 5122-29-37 Detoxification program certification
10. MCG, 20th Edition Guidelines; Substance Related Disorders, Clinical Indications for Admission to Inpatient Care

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

The medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.