MEDICAL POLICY STATEMENT

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
06/01/2012	07/15/2016	07/15/2015

Policy Name	Policy Number
Acute In-Patient Detoxification (Opioid) PA Criteria	**MM-0019**

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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

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. 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. 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)
   H. 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."
   I. 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. <u>Ohio</u>
      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
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. MCG, 19th Edition Guidelines; Substance-Related Disorders, Clinical Indications for Admission to Inpatient Care.
2. Suboxone [package insert]. Richmond, VA,: Reckitt Benckiser Pharmaceuticals Inc.; April 2014
3. Subutex [package insert}. Richmond, VA,: Reckitt Benckiser Pharmaceuticals Inc.; April 2014
4. Drugs. 2009; 69 (5):577-607.
5. McConnaughy, 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.
6. 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.
7. 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.
8. International Psychopharmacology Algorithm Project, Opioid Algorithm (2013 update).
9. 902 KAR 20:111. Medical detoxification services
10. OAC 3793:2-6-01 Detoxification program certification

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.