

# MEDICAL POLICY

<b>POLICY TITLE</b>	<b>OPIOID ANTAGONISTS UNDER HEAVY SEDATION OR GENERAL ANESTHESIA AS A TECHNIQUE OF OPIOID DETOXIFICATION</b>
<b>POLICY NUMBER</b>	<b>MP-2.303</b>

<b>Effective Date:</b>	<b>9/1/2022</b>
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## I. POLICY

Opioid antagonists under heavy sedation or anesthesia is considered **investigational** as a technique for opioid detoxification (i.e., ultra-rapid detoxification), as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

## II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

**FEP PPO** - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: <https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies>

## III. DESCRIPTION/BACKGROUND

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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 (e.g., oral opioid antagonists and psychosocial support).

The traditional treatment of opioid addiction involves substituting the opiate (i.e., 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 addiction, 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 substitute's 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 (i.e., 6 months) of withdrawal. Although typically not life threatening, acute detoxification symptoms include irritability, anxiety, apprehension, muscular

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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, naloxene, or nalmefene under deep sedation with benzodiazepine or general anesthesia. This strategy has been referred to as "ultra-rapid," "anesthesia assisted," or "one-day" detoxification. The use of opioid antagonists accelerates 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 Rehabilitation, 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, 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.

### Regulatory Status

In October 2002, the buprenorphine monotherapy product, Subutex®, and a buprenorphine/naloxone combination product, Suboxone® (both Reckitt Benckiser) received approval under a new drug application by the U.S. Food and Drug Administration for use in opioid addiction treatment.

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### IV. RATIONALE

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#### Summary of Evidence

The evidence for ultrarapid detoxification under general anesthesia in individuals who have opioid addiction includes both randomized and nonrandomized clinical trials, as well as prospective follow-up studies, which compare other approaches not involving deep or general anesthesia. Relevant outcomes are change in disease status, treatment-related morbidity, and mortality, in addition to continued abstinence from opioids or relapse to daily opioid use. There is a paucity of data in the controlled trials and a lack of standardized approach to ultrarapid detoxification. Additionally, significant adverse effects, including life-threatening complications, are a concern using this treatment. Most patients subsequently return to daily use shortly after this technique. The evidence is insufficient to determine the effects of the technology on health outcomes.

### V. DEFINITIONS

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**OPIOID** refers to any synthetic narcotic not derived from opium

### VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

### VII. DISCLAIMER

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*Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice, and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.*

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### VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

***\*No specific CPT codes\****

### IX. REFERENCES

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### X. POLICY HISTORY

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<b>MP 2.203</b>	<b>CAC 5/27/03</b>
	<b>CAC 4/26/05</b>
	<b>CAC 4/25/06</b>
	<b>CAC 4/24/07</b> Consensus
	<b>CAC 5/27/08</b> Consensus
	<b>CAC 5/26/09</b> Consensus
	<b>CAC 5/25/10</b> Consensus
	<b>CAC 9/10</b> Adopted BCBSA Guidelines
	<b>CAC 7/26/11</b> Consensus
	<b>CAC 8/28/12</b> Consensus, no change to policy statements, references updated Codes reviewed 8/20/12
	<b>CAC 07/30/13-</b> Consensus review. Admin code review complete.
	<b>CAC 3/25/14</b> Consensus. No change to policy statements. References updated. Rationale section added. Coding complete.
	<b>CAC 3/24/15</b> Consensus review. No change to the policy statement. Reference and rationale updated. Coding reviewed.
	<b>CAC 3/29/16</b> Consensus review. No change to policy statement. References and rationale updated. Coding reviewed.
	<b>Admin update 1/1/17:</b> Product variation section reformatted.
	<b>CAC 5/23/17</b> Consensus. No change to policy statements. References reviewed. Coding Reviewed.
<b>1/1/18 Admin Update:</b> Medicare variations removed from Commercial Policies.	
<b>2/08/18 Consensus review.</b> Policy statement unchanged. Rationale and Reference sections updated.	

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	<b>2/11/19 Consensus.</b> No change to policy statements. Rationale condensed. References reviewed.
	<b>3/2/20 Consensus review.</b> No change to policy statement. References updated.
	<b>3/5/2021 Consensus review.</b> Policy statement unchanged. References updated.
	<b>6/8/2022 Consensus review.</b> Updated FEP and references.

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