MEDICAL POLICY

POLICY TITLE	**MEDICATIONS USED UNDER HEAVY SEDATION OR GENERAL ANESTHESIA FOR OPIOID USE DISORDER (FORMERLY OPIOID ANTAGONISTS UNDER HEAVY SEDATION OR GENERAL ANESTHESIA AS A TECHNIQUE OF OPIOID DETOXIFICATION)**
POLICY NUMBER	**MP 2.303**

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**4/1/2024**

I. POLICY

Medications used under heavy sedation or anesthesia is considered **investigational** for opioid use disorder (i.e., ultra-rapid withdrawal management), as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

II. PRODUCT VARIATIONS TOP

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 TOP

The use of relatively high doses of antagonist medications for opioid use disorder (e.g. naloxone) under deep sedation or general anesthesia is a technique for opioid withdrawal management and is known as ultra-rapid withdrawal management. It is a potential alternative to standard withdrawal management that allows patients to avoid the acute symptoms associated with initial withdrawal. Ultra-rapid withdrawal management is used in conjunction with medication for opioid use disorder and psychosocial support.

The traditional treatment of opioid use disorder involves substituting the opiate with an equivalent dose of a longer acting opioid agonist (e.g. methadone) followed by tapering to a

continuous medication treatment dose. Continuous medication treatment therapy does not resolve opioid use disorder, 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 continuous medication treatment point out that this strategy substitutes one drug of dependence for the indefinite use of another. Withdrawal management followed by abstinence is another treatment option, which can be used as the initial treatment of opioid use disorder, or offered as a final treatment strategy for patients on continuous medication treatment. Withdrawal is associated with acute symptoms followed by a longer period of protracted symptoms (i.e., 6 months). Although typically not life threatening, acute withdrawal 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.

Withdrawal management may be initiated with tapering doses of methadone or buprenorphine (an opioid agonist-antagonist), treatment with a combination of buprenorphine and naloxone, 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, withdrawal is associated with patient discomfort, and many patients may be unwilling to attempt withdrawal management. In addition, withdrawal management is only the first stage of treatment. Without ongoing medication and psychosocial support after withdrawal, the probability is low that any withdrawal management procedure alone will result in lasting abstinence.

Dissatisfaction with current approaches to withdrawal management 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," or "one-day" withdrawal management. The use of opioid antagonists accelerates the acute phase of withdrawal, 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 withdrawal management is then followed by ongoing support for the protracted symptoms of withdrawal. In addition, naltrexone may be continued to discourage relapse.

Ultra-rapid withdrawal management 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 withdrawal management under anesthesia, and finally, mandatory post-withdrawal management care and follow-up. The program may be offered to patients with opioid

use disorder. Once acute withdrawal management is complete, the opioid antagonist naltrexone is often continued to decrease drug craving, with the hope of reducing the incidence of relapse.

IV. RATIONALE

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Summary of Evidence

The evidence for ultrarapid withdrawal management under general anesthesia in individuals who have opioid use disorder 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 withdrawal management. 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.

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

TOP

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14. *Berlin D, Farmer BM, Rao RB, Rella J, Kunins H, Dowell D, Graber N, Hoffman RS, Karpati A, Weiss D, Jones C. Deaths and severe adverse events associated with*

anesthesia-assisted rapid opioid detoxification—New York City, 2012. MMWR. Morbidity and mortality weekly report. 2013 Sep 27; 62(38):777.

15. *Stolbach, A and Hoffman R. Opioid withdrawal in the emergency setting In: UpToDate Online Journal [serial online]. Waltham, MA: UpToDate; updated October 26, 2023. Literature review current through November 2023.*
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17. *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update [published correction appears in J Addict Med. 2020 May/Jun;14(3):267]. J Addict Med. 2020;14(2S Suppl 1):1-91. Doi:10.1097/ADM.0000000000000633*
18. *Blue Cross Blue Shield Association Medical Policy Reference Manual. 3.01.02, Opioid Antagonists Under Heavy Sedation or General Anesthesia as a Technique of Opioid Detoxification. Archived January 2016.*

X. POLICY HISTORY

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

	reviewed. Coding Reviewed.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies.
	2/08/18 Consensus review. Policy statement unchanged. Rationale and Reference sections updated.
	2/11/19 Consensus. No change to policy statements. Rationale condensed. References reviewed.
	3/2/20 Consensus review. No change to policy statement. References updated.
	3/5/2021 Consensus review. Policy statement unchanged. References updated.
	6/8/2022 Consensus review. Updated FEP and references.
	12/28/2023 Consensus review. Editorial refinements to policy statement, background section, and rationale (outdated language replaced with current medical terminology); no change to intent. Title change. Updated references.

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