Easy Choice Health Plan

Missouri Care

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona

OneCare (Care1st Health Plan Arizona, Inc.)

Staywell of Florida

WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

WellCare Prescription Insurance

WellCare Texan Plus (Medicare – Dallas & Houston markets)

Psychological Testing for Opioid Dependence (E/I)

Policy Number: HS-288

Original Effective Date: 1/7/2016

Revised Date(s): 11/3/2016; 9/7/2017; 9/6/2018

APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

BACKGROUND

There are typically six major categories of treatment options for chronic pain: pharmacologic, physical medicine, behavioral medicine, neuromodulation, interventional, and surgical approaches. Ideal patient outcomes typically use various approaches that are coordinated with a multidisciplinary team. Collaborative care models in primary care can improve pain management and patient outcomes. Medication should not be the sole focus of treatment, but should be used when needed, in conjunction with other treatment modalities, to meet treatment goals. Ongoing monitoring, evaluation, education and encouragement, and aiding the patient in establishing reasonable expectations are necessary. Research shows an approximate 30 percent decrease in pain; this can significantly improve a patient's quality of life.

Prior to beginning chronic opioid therapy, the patient should be evaluated; this includes an assessment of risks and benefits of therapy established based on the history, physical examination, and assessment of the risk of substance

abuse, misuse, or addiction. A positive drug history in the patient or in a family member is a strong factor for drug-related behaviors related to chronic opioid therapy. A personal history of past drug abuse may be considered a contraindication to long-term opioid therapy, although this remains controversial. Guidelines from the American Pain Society and the American Academy of Pain Medicine recommend that patients at high risk be evaluated by a mental health or addiction specialist, and be willing to comply with more frequent and stringent monitoring. The benefit-to-harm evaluation of chronic opioid therapy should be considered and documented on an ongoing and periodic basis during treatment with chronic opioids.

Guidelines that have been established for opioid therapy should be followed closely including monitoring after initiation of opioid therapy as risk for an adverse event is highest after initiation of therapy. Also, those receiving higher doses are at increased risk for overdose. Providers should adjust doses using a goal-directed manner; increases are dependent upon demonstrable functional improvement by the patient.

In addition, prior to beginning chronic opioid therapy, patients should be assessed for any psychological impact that pain causes in the patient's life. This may yield a psychological comorbidity that could interfere with treatment as well as put the patient at risk for opioid addiction. Referrals should be made accordingly. Ongoing psychological support should be available to those receiving chronic opioid therapy. Providers can stratify a patient's estimated risk of problematic drug-related behavior; this allows the provider to determine if treatment with a controlled prescription drug is advisable without assistance from a specialist.

Questions to include during a clinical assessment includes the following questions:

1. Is there a personal history of alcohol or drug abuse?
2. Is there a family history of alcohol or drug abuse?
3. Does the patient have a major psychiatric disorder?

If a patient states that any of the above are present, this indicates an elevated risk for problematic drug-related behavior. Additional factors may also be important to consider – for example, younger age of patient, smoking history, social isolation or involvement with a drug abuse subculture, history of multiple automobile accidents, and inability to maintain employment.

Naloxone Challenge Test (NCT)

The NCT is performed to assess physical dependence; the opioid antagonist drug naloxone is administered to determine a person's current level of physical dependence on opioids. A positive test is indicative of physical dependence and consists of typical withdrawal symptoms and signs. These symptoms and signs usually last for 30-60 minutes. The test is found to be helpful before starting opiate antagonists for maintenance therapy. Starting opioid antagonists, such as naltrexone, soon after detoxification may cause withdrawal symptoms and discourage patients from further treatment.

American Society of Addiction Medicine

Patients being evaluated for addiction involving opioid use, and/or for possible medication use in the treatment of opioid use disorder, should undergo/have completed an assessment of mental health status and psychiatric disorders. Opioid use is often co-occurring with other substance related disorders. An evaluation of past and current substance use and a determination of the totality of substances surrounding the addiction should be conducted.

Concomitant use of alcohol and sedatives, hypnotics, or anxiolytics with opioids may contribute to respiratory depression. Patients with significant co-occurring substance use disorders, especially severe alcohol or sedative, hypnotic, or anxiolytic use, may require a higher level of care. A tobacco use query and counseling on cessation of tobacco products should be completed routinely for all patients, including those who present for evaluation and treatment of opioid use disorder.

An assessment of social and environmental factors should be conducted to identify facilitators and barriers to addiction treatment, and specifically to pharmacotherapy. Before a decision is made to initiate a course of pharmacotherapy for the patient with opioid use disorder, the patient should receive a multidimensional assessment in fidelity with *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.*

Addiction should be considered a bio-psycho-social-spiritual illness, for which the use of medication(s) is but only one component of overall treatment. Other clinicians may diagnose opioid use disorder, but confirmation of the diagnosis by the provider with prescribing authority, and who recommends medication use, must be obtained before pharmacotherapy for opioid use disorder commences. Opioid use disorder is primarily diagnosed on the basis of the history provided by the patient and a comprehensive assessment that includes a physical examination.

Validated clinical scales that measure withdrawal symptoms, for example, the Objective Opioid Withdrawal Scale (OOWS), the Subjective Opioid Withdrawal Scale (SOWS), and the Clinical Opioid Withdrawal Scale (COWS), may be used to assist in the evaluation of patients with opioid use disorder.

NOTE: Such scales are not considered formal psychological testing, are done as part of a clinical evaluation, and are not billable services.

POSITION STATEMENT

Applicable To:

- ☑ Medicaid
- ☑ Medicare

Psychological testing for diagnosis of opioid dependency **is considered experimental and investigational** as psychological testing is not needed for the treatment of opioid dependence. In addition, relapse potential can be assessed without the need for psychological testing.

Reference *HS 203: Use and Approval of Psychological Testing* as applicable.

CODING

There are no applicable Covered CPT or ICD10-CM diagnoses codes.

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	Action
9/6/2018, 9/7/2017, 11/3/2016	• Approved by MPC. No changes.
1/7/2016	• Approved by MPC. New.