Substance Use Disorders

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of substance use disorders (SUDs). The CPG discusses types of disorders as well as the assessment; psychiatric management; available treatments; formulation and implementation of a treatment plan; treatment settings; and clinical features influencing treatment. Behavioral health implications are also explored. Objectives and measureable health outcomes with respect to Care Management are included. In addition, the CPG outlines the organizations that WellCare aligns with regarding SUDs and Measureable Health Outcomes.

OVERVIEW

Substance use disorders are defined as mild, moderate, or severe to indicate the level of severity; this is determined by the number of diagnostic criteria met by a member. A disorder occurs when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Types of SUDs include: Alcohol, Tobacco, Cannabis (Marijuana), Cocaine, Stimulant, Hallucinogen, and Opioid Use. For additional information regarding types of SUDs, please refer to the Addendum at the end of this CPG.[1]

For screening information related to substance use, visit the United States Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org. In addition, refer to the following preventive CPGs: *Adult Preventive Health: HS-1019, Pediatric Preventive Health: HS-1019, Adolescent Preventive Health: HS-1051,* and *Preventive Health for Older Adults: HS-1063.*

Hierarchy of Support

CPGs are updated annually or as necessary due to updates made to American Psychiatric Association (APA) guidelines. When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to Substance Use Disorders, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the American Psychiatric Association (APA) on the topic of Substance Use Disorders. Highlights from the organizations are noted below.

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AMERICAN PSYCHIATRIC ASSOCIATION (APA)

WellCare adopts the 2006 practice guideline on Substance Use Disorders set forth by the American Psychiatric Association (APA). The document can be accessed at http://psychiatryonline.org/guidelines. The APA stresses that while many of the principles contained within the guideline apply to all substances reviewed in the guideline (e.g., nicotine, alcohol, marijuana, cocaine, and opioids), some may not be applicable to the treatment of every substance use disorder. For example, treatment for nicotine dependence rarely causes the behavioral or social harm seen with other substance dependencies. Providers should be mindful of clinically important features such as:[4]

- Number and type of substances used
- Member's genetic vulnerability for developing a substance use disorder(s)
- Severity of the disorder, rapidity with which it develops, and degree of associated functional impairment(s)
- Member's awareness of the substance use disorder as a problem
- Member's readiness for change and motivation to enter into treatment for the purpose of change
- Any associated general medical and psychiatric conditions (either co-occurring or induced by substance use)
- Member's strengths (protective and resiliency factors) and vulnerabilities
- Social, environmental, and cultural context in which the individual lives and will be treated

NOTE: It is clinically helpful when assessing members to use a spectrum that includes use, misuse, abuse, and dependence.

Evidence Based Practice

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Measures of Compliance.*

NOTE: To access Clinical Policy Guiding Documents visit www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

Care Management

The goals of treatment include the achievement of abstinence or reduction in the use and effects of substances, reduction in the frequency and severity of relapse to substance use, and improvement in psychological and social functioning. To accomplish these goals, Providers should include the following elements of the treatment:

1. **Assessment.** A comprehensive psychiatric evaluation is essential to guide the treatment of a member with a substance use disorder and includes:
    - A detailed history of the member's past and present substance use and the effects of substance use on the member's cognitive, psychological, behavioral, and physiological functioning; **AND,**
    - A general medical and psychiatric history and examination; **AND,**
    - A history of psychiatric treatments and outcomes; **AND,**
    - A family and social history; **AND,**
    - Screening of blood, breath, or urine for substance used; **AND,**
    - Other laboratory tests to help confirm the presence or absence of conditions that frequently co-occur with substance use disorders; **AND,**
    - Pending member's permission, contacting a significant other for additional information.
2. **Psychiatric management.** Psychiatric management is the foundation of treatment for members with substance use disorders. Psychiatric management has the following specific objectives: motivating the member to change, establishing and maintaining a therapeutic alliance with the member, assessing the member's safety and clinical status, managing the member's intoxication and withdrawal states, developing and facilitating the member's adherence to a treatment plan, preventing the member's relapse, educating the member about substance use disorders, and reducing the morbidity and sequelae of substance use disorders. Psychiatric management is generally combined with specific treatments carried out in a collaborative manner with professionals of various disciplines at a variety of sites, including community-based agencies, clinics, hospitals, detoxification programs, and residential treatment facilities.
    a) **Many members benefit from involvement in self-help group meetings; such involvement can be encouraged as part of psychiatric management.**

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3. **Specific treatments.** Pharmacological and psychosocial treatments are discussed in detail in the APA guidelines. Psychiatric management may include pharmacological interventions combined with specific treatments carried out in a collaborative manner with professionals of various disciplines including community-based agencies, clinics, hospitals, detoxification programs and residential treatment facilities.
4. **Formulation and implementation of a treatment plan.** The goals of treatment and the specific therapies chosen to achieve these goals may vary among members and even for the same member at different phases of an illness. Because many substance use disorders are chronic, members usually require long-term treatment, although the intensity and specific components of treatment may vary over time. Duration of treatment will vary by member. The treatment plan includes:
    - Psychiatric management; **AND,**
    - A strategy for achieving abstinence or reducing the effects or use of substances of abuse; **AND,**
    - Efforts to enhance ongoing adherence with treatment program, prevent relapse, and improve functioning; **AND,**
    - Additional treatments necessary for members with a co-occurring mental illness or general medical condition.
5. **Treatment settings.** Settings vary with regard to the availability of specific treatment modalities, the degree of restricted access to substances that are likely to be abused, the availability of general medical and psychiatric care, and the overall milieu and treatment philosophy. Members should be treated in the least restrictive setting that is likely to be safe and effective. Commonly available treatment settings include hospitals, residential treatment facilities, partial hospitalization programs, and out member programs. Decisions regarding the site of care should be based on the ability to cooperate with and benefit from the treatment offered, refrain from illicit use of substances, and avoid high-risk behaviors as well as the patient's need for structure and support or particular treatments that may be available only in certain settings. Members move from one level of care to another based on these factors and an assessment of their ability to safely benefit from a different level of care.[1]

Clinical features influencing treatment. In planning and implementing treatment, a clinician should consider several variables with regard to members: comorbid psychiatric and general medical conditions, gender-related factors, age, social milieu and living environment, cultural factors, gay/lesbian/bisexual/transgender issues, and family characteristics. Given the high prevalence of comorbidity of substance use disorders and other psychiatric disorders, the diagnostic distinction between substance use symptoms and those of other disorders should receive particular attention, and specific treatment of comorbid disorders should be provided. In addition to pharmacotherapies specific to a member's substance use disorder, various psychotherapies may also be indicated when a member has a co-occurring psychiatric disorder, psychosocial stressors, or other life circumstances that exacerbate the substance use disorder or interfere with treatment. A member's cessation of substance use may also be associated with changes in his or her psychiatric symptoms or the metabolism of medications (e.g., altered antipsychotic metabolism via cytochrome P450 1A2 with smoking cessation) that will necessitate adjustment of psychotropic medication doses.

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **SYMPTOMS:** Improved Member sobriety through increased coping skills. Compare Member response to CAGE Assessment questions related to symptom changes to substance use pre- and post- engagement at 6-12 months. In absence of data sources, Provider and Member narrative may be used.
- **ADHERENCE:** Improved Member adherence to medication and attendance of substance use treatment/appointments. Compare pharmacy and office visit claims data pre-and post- engagement to validate adherence to timely refill of the prescribed medication(s) and provider visit(s). In absence of pharmacy and office visit claims data, the Member narrative and/or professional reporting of adherence to medication and attendance of behavioral health related appointments may be used.
- **ENGAGEMENT:** Improved Member social engagement/social support system with others through meaningful roles and relationships in his/her social life, educational and occupational settings. Compare member narrative pre- and post- engagement at 6-12 months.
- **UTILIZATION:** Decreased Member substance use episodes leading to emergency room visits and hospital stays. Compare utilization data pre- and post- engagement 6-12 months. In absence of data sources, Provider and Member narrative may be used.

CASE MANAGEMENT GOALS

Case Goals Should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above, for example:

- **SYMPTOMS:** Reduction of behavioral health symptoms by 10% using valid, reliable rating scales (e.g. BDRS, HAM-D, GAD, etc.).
- **SYMPTOMS:** Member describes a routine that includes checking and logging behavioral health symptoms per treatment recommendation over the last 30 days and shares data with treatment provider.
- **SYMPTOMS:** Member describes coping skills and support system over the last 30 days that demonstrates improved adherence to guideline and/or treatment recommendations.
- **ADHERENCE:** Attendance of >75% of behavioral health and medical appointments during a 90-day period
- **ADHERENCE:** Member's prescription refills demonstrate at least an 80% adherence rate (verified by claims or member/provider narrative) over last 30 days.
- **ENGAGEMENT:** Increased frequency of social engagement by **≥25%** over previous period as measured by number of social interactions (self-report).
- **UTILIZATION:** Documentation of use the of Therapist visit, Case Management intervention, Crisis Line call, Primary Care Physician call or visit, or Urgent Care visit ***prior*** to emergency department visit or BH Inpatient Admission **≥75%** of the time.
- Specific for Members requiring hospitalization: The Member participates in provider follow-up visit within 7 days of hospital discharge.

CASE MANAGEMENT OBJECTIVES

Case Management Objectives should focus on improving the member's self-management skills and mental health, while encouraging sobriety, through:

- Implement Behavioral Health Care Plan
- Review member's drug history
- Identify member's drug of choice
- Assess level of motivation for sobriety, identifying longest period of sobriety
- Review hat worked in the past to maintain sobriety
- Utilize motivational interviewing techniques to promote sobriety
- Provide information regarding community and treatment resources
- Refer to professional resources including: Substance use treatment options, psychiatry, counseling, etc.
- Provide medical resources necessary to maintain positive physical health
- Encourage attendance of scheduled appointments
- Encourage adherence of prescribed medication
- Encourage of sober social contact and interaction within sober social groups and social supports

OTHER CONSIDERATIONS

Substance use can have significant impact on physical and mental health. The following outlines common substances that are misused or abused along with their most common impacts to well-being that the care team should assess for:[5]

- **Nicotine** use increases a user's risk of cancer, emphysema, bronchial disorders, and cardiovascular disease.
- **Alcohol** consumption can damage most body organs including the brain with long-term effects on brain functions like problem solving, decision making, memory, learning, and movement coordination.
- **Marijuana** impairs short-term memory, learning, the ability to focus attention, and coordination. It also increases heart rate, can harm the lungs, and can increase the risk of psychosis in those vulnerable.
- **Prescription medications** when misused and abused can lead to addiction and even, in some cases, death. Example: crushing pills then injecting or snorting, greatly raises the risk of addiction and overdose.
- **Inhalants** are extremely toxic to the heart, kidneys, lungs, and brain. Heart failure and death can occur within minutes of a single session.
- **Cocaine** use can severely impact the heart and the respiratory, nervous, and digestive systems.
- **Amphetamines** can cause high body temperature and can lead to serious heart problems and seizures.
- **Methamphetamines** effects are particularly long-lasting and harmful to the brain.
- **MDMA** (Ecstasy or "Molly") can increase body temperature, heart rate, blood pressure, and heart-wall stress.

MDMA may also be toxic to nerve cells.

- **LSD** effects are unpredictable and abusers usually have hallucinations. Users also may have traumatic experiences and emotions that can last for many hours.
- **Heroin** slows respiration, and its use is linked to an increased risk of serious infectious diseases, especially when taken intravenously.
- **Steroids**, when abused, can include severe acne, heart disease, liver problems, stroke, infectious diseases, depression, and suicide.
- **Drug combinations**. Because of drug–drug interactions, such practices often pose significantly higher risks than the already harmful individual drugs, such as the dangerous mixing of prescription drugs, and the deadly combination of heroin or cocaine with fentanyl (an opioid pain medication).

MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to substance use disorders.

- Recognizing the Signs of Substance Abuse in Teens
- When you Suspect Your Child is Using Alcohol or Drugs
- For Teens: Understand the Cycle of Addiction
- Signs of Addiction: Social Use
- Understanding the Disease of Addiction
- Understanding Inhalant Abuse
- Understanding Methamphetamine Abuse and Addiction
- Understanding Marijuana Abuse
- Understanding Heroin Abuse and Addiction
- Addiction: Ask Yourself These Questions
- Addiction: Getting Help
- Cocaine: Getting Help
- Alcoholism: Getting Help
- Alcoholism: Resources for Family and Friends
- Treating Heroin Addiction
- Treating Drug Abuse and Addiction
- Treating Inhalant Abuse
- Life After Combat: Coping with Alcohol Abuse
- Recovering from Addiction: Continuing with Counseling
- Recovering from Addiction: Coping with Relapse
- Recovering from Addiction

These materials are in the approval process and will be available for member educational mailing in the future. Providers may wish to research the titles above related to substance use disorders that Case Managers utilize with Members.

Market Specific Items

FLORIDA

WellCare uses the *Florida Supplement to the American Society of Addictions Medicine Member Placement Criteria* (2nd ed.) (ASAM PPC-2R) for the coordination of mental health treatment with substance abuse providers as part of the integration effort. Criteria is available at http://www.sfbhn.org/policies/asam%20suplement%20forms.pdf [3]

Related WellCare Guidelines

In addition to the information contained in this CPG, please reference *Substance Use Disorders in Pregnancy: HS-1041.* NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then "Tools" and "Clinical Guidelines".

References

1. Substance use disorders. Substance Abuse and Mental Health Services Administration Web site. http://www.samhsa.gov/disorders/substance-use. Published October 27, 2015. Accessed November 16, 2016.
2. Drug use, illicit: primary care interventions for children and adolescents. United States Preventive Services Task Force Web site. http://www.uspreventiveservicestaskforce.org/. Published 2014. Accessed December 7, 2015.
3. Drug use, illicit: screening. United States Preventive Services Task Force Web site. http://www.uspreventiveservicestaskforce.org/. Published 2008. Accessed December 7, 2015.
4. Practice guideline for the treatment of patients with substance use disorders (2nd ed.). American Psychiatric Association Web site. http://psychiatryonline.org/guidelines. Published 2006. Accessed August 14, 2015.
5. Drugs, brains, and behavior: the science of addiction. National Institute on Drug Abuse Web site. https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health. Published July 2014. Accessed December 7, 2016.

Disclaimer

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
10/10/2017	• Approved by MPC. No changes.
12/8/2016	• Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors.
8/19/2016	• Approved by MPC. Updated per regulatory requirements.
12/11/2015	• Approved by MPC. Inclusion of section on children and adolescents.
9/17/2015	• Approved by MPC. Inclusion of items regarding the use of Chantix (varenicline).
3/5/2015	• Approved by MPC. Inclusion of Care Management Training items.
8/7/2014	• Approved by MPC. Included updated HEDIS measure.
7/31/2014	• Approved by MPC. Biennial review.
7/5/2012	• Approved by MPC. New.

Addendum

Specific SUDs are outlined below as defined by the American Psychiatric Association (APA):[1,4]

Nicotine Use Disorders

1. *Pharmacological treatment is recommended for individuals who wish to stop smoking and have not achieved cessation without pharmacological agents or who prefer to use such agents*. There are six medications approved by the U.S. Food and Drug Administration (FDA) for nicotine dependence, including five NRTs (patch, gum, spray, lozenge, and inhaler), varenicline, and bupropion. These are all first-line agents that are equally effective in alleviating withdrawal symptoms and reducing smoking. Any of these could be used based on member preference, the route of administration, and the side-effect profile. Significant adverse events to NRTs, including dependence, are rare. Although combined psychosocial and medication treatment produces the best outcomes in treating nicotine use disorders, these medications are effective even when no psychosocial treatment is provided. Using a combination of these first-line treatments may also improve outcome. Nortriptyline and clonidine have utility as second-line agents but appear to have more side effects. Other medications and acupuncture have not been proven to be effective.
2. *Psychosocial treatments are also effective for the treatment of nicotine dependence and include CBTs, behavioral therapies, brief interventions, and MET provided in individual, group, or telephone formats or via self-help materials and Internet-based formats*.

In addition, the current black box warning for Chantix notes that serious neuropsychiatric events have been reported by those who take Chantix. Members should stop taking Chantix and contact a healthcare provider immediately if they experience agitation, hostility, depressed mood, or changes in behavior or thinking that is not typical, or if the patient develops suicidal ideation or suicidal behavior. A phase IV, randomized, double-blind, active and placebo-controlled, multicenter study evaluating the neuropsychiatric safety and efficacy of Chantix and bupropion is underway; at the time of review, data was not yet available. The FDA Advisory Committee noted that a change in labeling should not be considered until data from this trial are available for consideration.[2]

Alcohol Use Disorders

1. *Management of intoxication and withdrawal*. The acutely intoxicated member should be monitored and maintained in a safe environment. Symptoms of alcohol withdrawal typically begin within 4–12 hours after cessation or reduction of alcohol use, peak in intensity during the second day of abstinence, and generally

resolve within 4–5 days. Serious complications include seizures, hallucinations, and delirium. The treatment of members in moderate to severe withdrawal includes efforts to reduce central nervous system (CNS) irritability and restore physiological homeostasis and generally requires the use of thiamine and fluids, benzodiazepines, and, in some members, other medications such as anticonvulsants, clonidine, or antipsychotic agents. Once clinical stability is achieved, the tapering of benzodiazepines and other medications should be carried out as necessary, and the member should be observed for the reemergence of withdrawal symptoms and the emergence of signs and symptoms suggestive of co-occurring psychiatric disorders.

2. *Pharmacological treatments*. Specific pharmacotherapies for alcohol-dependent members have well-established efficacy and moderate effectiveness. Naltrexone may attenuate some of the reinforcing effects of alcohol, although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may also promote adherence. Acamprosate, a γ-aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated members who are concomitantly receiving psychosocial treatment. Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated members whose drinking may be triggered by events that suddenly increase alcohol craving.
3. *Psychosocial treatments found effective for some members with an alcohol use disorder include MET, CBT, behavioral therapies, TSF, marital and family therapies, group therapies, and psychodynamic therapy/IPT.* Member participation in self-help groups (e.g., Alcoholics Anonymous [AA]) should be encouraged.

Marijuana Use Disorders

Studies of treatment for marijuana use disorders are limited. No specific pharmacotherapies for marijuana withdrawal or dependence can be recommended. In terms of psychosocial therapies, an intensive relapse prevention approach that combines motivational interventions with the development of coping skills may be effective for the treatment of marijuana dependence, but further study of these approaches is necessary.

Cocaine Use Disorders

1. *Management of intoxication and withdrawal.* Cocaine intoxication is usually self-limited and typically requires only supportive care. However, hypertension, tachycardia, seizures, and persecutory delusions can occur with cocaine intoxication and may require specific treatment. Acutely agitated members may benefit from sedation with benzodiazepines.
2. *Pharmacological treatment is not ordinarily indicated as an initial treatment for members with cocaine dependence.* In addition, no pharmacotherapies have FDA indications for the treatment of cocaine dependence. However, for individuals who fail to respond to psychosocial treatment alone, some medications (topiramate, disulfiram, or modafinil) may be promising when integrated into psychosocial treatments.
3. *Psychosocial treatments.* For many members with a cocaine use disorder, psychosocial treatments focusing on abstinence are effective. In particular, CBTs, behavioral therapies, and 12-step-oriented individual drug counseling can be useful, although efficacy of these therapies varies across subgroups of members. Recommending regular participation in a self-help group may improve the outcome for selected members with a cocaine use disorder.

Opioid Use Disorders

1. *Management of intoxication and withdrawal*. Acute opioid intoxication of a mild to moderate degree usually does not require specific treatment. However, severe opioid overdose, marked by respiratory depression, may be fatal and requires treatment in an emergency department or inpatient setting. Naloxone will reverse respiratory depression and other manifestations of opioid overdose. The treatment of opioid withdrawal is directed at safely ameliorating acute symptoms and facilitating the member's entry into a long-term treatment program for opioid use disorders. Strategies found to be effective include substitution of methadone or buprenorphine for the opioid followed by gradual tapering; abrupt discontinuation of opioids, with the use of clonidine to suppress withdrawal symptoms; and clonidine-naltrexone detoxification. It is essential that the treating physician assess the member for the presence of other substances, particularly alcohol, benzodiazepines, or other anxiolytic or sedative agents, because the concurrent use of or withdrawal from other substances can complicate the treatment of opioid withdrawal. Anesthesia-assisted rapid opioid detoxification (AROD) is not recommended because of lack of proven efficacy and adverse risk-benefit ratios.

2. *Pharmacological treatments*. Maintenance treatment with methadone or buprenorphine may be appropriate for some members with a prolonged history (>1 year) of opioid dependence. The goals of treatment are to achieve a stable maintenance dose of opioid agonist and facilitate engagement in a comprehensive program of rehabilitation. Maintenance treatment with naltrexone is an alternative strategy, although the utility of this strategy is often limited by lack of member adherence and low treatment retention.
3. *Psychosocial treatments are effective components of a comprehensive treatment plan for members with an opioid use disorder.* Behavioral therapies (e.g., contingency management), CBTs, psychodynamic psychotherapy, and group and family therapies have been found to be effective for some members with an opioid use disorder. Recommending regular participation in self-help groups may also be useful.