



Health Net

## Clinical Practice Guideline

**Subject: Substance Use Disorder**

**Policy Number: 474**

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**This Clinical Practice Guideline is subject to the terms in the  
IMPORTANT NOTICE  
at the end of this document**

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### OVERVIEW

The National Survey on Drug Use and Health (NSDUH) for 2016<sup>1</sup> found that among Americans age 12 and over 51.3 million were current cigarette smokers, 65.3 million reported binge alcohol use (4+ drinks for women and 5+ drinks for men on the same occasion) and 16.3 million reported heavy alcohol use (binge drinking on 5 or more days in the past 30 days) in the past month, and 28.6 million used an illicit drug in the past 30 days. In 2016, an estimated 11.8 million people misused opioids in the past year, including 11.5 million pain reliever misusers and 948,000 heroin users. According to data from the NIAAA<sup>31</sup>, more than 10% of children in the United States live with a parent with alcohol problems. About 88,000 people (approximately 62,000 men and 26,000 women) die from alcohol-related causes annually, making alcohol the third leading preventable cause of death in the United States. The first is tobacco, and the second is poor diet and physical inactivity. In 2014, alcohol-impaired driving fatalities accounted for 9,967 deaths (31 percent of overall driving fatalities). In 2010, alcohol misuse cost the United States \$249 billion. Three-quarters of the total cost of alcohol misuse is related to binge drinking. A 2011 estimate of Substance Use Disorders Costs to the American Economy is over \$700 billion.<sup>7</sup> All health care professionals, therefore, are likely to come in contact with individuals who abuse or are dependent upon substances and are in a unique position to evaluate for these conditions and motivate patients to seek appropriate treatment interventions.

Despite the growing diversity of treatment options, however, only 14.6% of people with alcohol abuse or dependence receive treatment according to the data from the NIAAA's 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions<sup>27</sup>. In 2009, an estimated 7 million Americans were abusing prescription drugs, more than the number abusing cocaine, heroin, hallucinogens and inhalants combined. Emergency-room visits related to non-medical use of opioids rose 111% between 2004 and 2008. Between 1998 and 2008 the rate of opioid prescription misuse is estimated to have increased 400%. According to the National Institute of Drug Abuse (NIDA) young adults (age 18-25) are the biggest abusers of prescription opiate pain relievers, stimulants and anxiolytics. In 2010 almost 3000 young adults died (8 persons per day) as a result of prescription drug overdoses (mostly opiates) and that is more than overdoses with any other drug, including heroin and cocaine combined. Many more required emergency care (for every death due to Rx drug overdose, there were 17 treatment admissions and 66 emergency room visits). In

the United States, drug overdose is now the leading cause of accidental death, as well as the leading cause of death in those under 50. According to CDC, drug-poisoning deaths involving opioids have quadrupled from 1999 (1.4/ 100000) to 2011 (5.4/100000). Benzodiazepines were involved in 31% of such poisonings in 2011 (a 13% increase from 1999).

## DIAGNOSTIC CONSIDERATIONS

### **Substance Use Disorder**

**Substance use disorder** is defined as a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. These maladaptive pattern of behaviors leading at the minimum to **clinically significant impairment or distress**, as manifested by at least **two** of the following:



#### IMPAIRED CONTROL

- larger amounts taken or over a longer period than was originally intended
- persistent desire to cut down or regulate use and may report multiple unsuccessful efforts to decrease or discontinue use
- great deal of time to obtain, use or recovering from its effects

craving: defined as a manifestation by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used

#### SOCIAL IMPAIRMENT

- Recurrent substance abuse resulting in a failure to fulfill major role obligations at work, school, or home
- Continued substance use despite persistent or recurrent social or interpersonal problems related to the substance.

Important social, occupational, or recreational activities may be given up or reduced because of substance use

#### RISKY USE

- Recurrent substance use in situations in which it is physically hazardous
- Failure to abstain from substances despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

#### PHARMACOLOGICAL CRITERIA

- Tolerance – either requiring a markedly increased dose of the substance or the chemical group the substance belongs to, for achievement of desired effect or a markedly reduced effect when usual dose is used
- Withdrawal – a symptom cluster that occurs characteristic for that substance or the chemical group the substance belongs to, potentially requiring a similar chemical substance to be taken to relieve or avoid the withdrawal

#### SEVERITY and SPECIFIERS

\*Based on a number of above symptom criteria, use as a general estimate to quantify severity:

- MILD- presence of two or three symptoms
- MODERATE- four or five symptoms
- SEVERE- six or more symptoms

**Substance-Induced Disorders** includes **Intoxication, Withdrawal** and **Other Substance/MEDICATION Induced Mental Disorders and medical complications.**

**Substance Intoxication:** Development of a reversible substance specific syndrome due to the recent use of a substance followed by:

- Psychological changes attributable to physiological effects of the substance on the Central Nervous System (CNS) such as disturbance in perception, wakefulness, attention, thinking, judgment, psychomotor activity and/ or interpersonal relatedness.
- Changes occur during or shortly after the use of the substance, and could not be readily explained by another mental disorder nor attributable to another medical condition.
- NOTE: This does not apply to tobacco.

**Withdrawal:** Physiological and psychological effects of cessation or reduction in heavier and prolonged use of a specific substance.

- Clinically significant distress that may be associate with impairment in social, occupational and/ or other areas of functioning.
- Symptoms could not be readily explained by another mental disorder nor attributable to another medical condition.

*\*Note: Tolerance and Withdrawal criteria do NOT count if it applies only to medication (opioids, sedatives, stimulants) taken under appropriate medical supervision*

**Substance/Medication-Induced Mental Disorder:** Potentially severe, usually temporary, but sometimes persisting CNS syndrome developing in the context of the effects of substances of abuse, medications or several toxins. All substance/medication-induced mental disorders may be induced by the 10 classes of substances use disorders or by variety of medications used in medical treatment. Common characteristics and features are described below:

Clinically significant symptomatic presentation of a relevant mental disorder.

Evidence from the history, physical examination, or laboratory findings of both of the following;

- Disorder developed during or within 1 month of substance intoxication or withdrawal or taking a medication; AND
- Involved substance/medication is capable of producing a mental disorder

Disorder is not better explained by an independent mental disorder which includes the following:

- The disorder preceded the onset or severe intoxication or withdrawal or exposure to the medication; OR
- The full mental disorder persisted for a substantial period of time (e.g. at least 1 month) after the cessation of acute withdrawal or severe intoxication or taking the medication or hallucinogen persisting perception disorder, which persist beyond the cessation of acute intoxication or withdrawal.

Delirium is not the cause

- Disorder causes clinically significant distress or impairment in social, occupational and/or other areas of functioning.

### **Assessment**

Given the statistical data cited above, it is clear that patients of all ages should be screened for substance use.

When assessing for substance use disorders (SUD), it is important to ask very specific questions. Patients will often downplay their use of substances. Obtaining information from additional sources (family, employer, medical) can be helpful.

The following are factors that should be assessed to determine the severity of SUD and the appropriate level of care. (Nicotine dependence as a primary substance use disorder will be considered elsewhere.)

***Include the following in the assessment:***



- Primary substances of choice and method of administration
- Onset and history of use
- All current substances used, including prescriptions, over-the-counter medications and supplements, and substances obtained from illicit sources or over the Internet
- Level and pattern of current use
- History of attempts to stop or control use
- Psychosocial assessment, including current support systems
- Medical Examination to rule out comorbid medical conditions, including screening of blood, breath or urine for substances used
- Psychiatric Evaluation to rule out comorbid psychiatric conditions and potential consequences of drug use on cognition
- Evaluate readiness for change to establish motivation for treatment

- Risk of withdrawal syndrome
- Potential for abuse/violence
- Suicide potential
- Social, family, legal, and occupational problems related to substance use
- Family history of SUD
- Current stressors
- Consider the use of assessment tools such as the CAGE, AUDIT, TWEAK and/or MAST and Opioid Risk Tool (ORT) for adults and the CRAAFT for adolescents (links to these tools can be found in the "Resources for Professionals" section)

## SUBSTANCE USE DISORDERS

### Treatment Interventions

#### **General Considerations**

#### **When selecting a treatment program:**



- If the patient has managed care benefits through MHN, call MHN to coordinate referral. If not, coordinate with the patient's insurance carrier or community programs.
- Programs should encourage each patient to create and manage an individualized recovery plan consistent with the program's treatment planning. This should include a broad spectrum of services, lab and toxicology screening, and pharmacotherapy for withdrawal syndromes, comorbid psychiatric and medical conditions and to assist in maintaining abstinence and building an adequate sober support system.
- Adolescents should be treated in programs specifically designed for that population.
- Consider issues of cultural diversity.
- Programs for all levels of care should stress abstinence and promote a 12-step facilitation (TSF) or other self-help or mutual-help groups (MHGs) orientation.
- It is generally preferable to select a program in the patient's community in order to foster the participation of family or other true personal social supports in treatment, to facilitate discharge planning and the transition back to the community, and to develop the patient's support system.
- Programs should start early in treatment to document preparation of referral to effective aftercare programs.

**Level of care  
Considerations:**



■ When making referral decisions, refer to the least restrictive level of care likely to be effective<sup>4</sup>.

■ Refer to a **23-hour Bed Observation** when the emerging clinical picture points toward high risks in the context of acute intoxication.

■ Refer to inpatient **detoxification programs** or specialists if there is likelihood of severe withdrawal. While detoxification can be performed in either an inpatient or outpatient setting, patients presenting with medical complications, or a history of organ failure, seizures or delirium tremens, comorbid psychiatric problems, or lack of availability of outpatient detoxification programs would typically necessitate more specialized inpatient detoxification.

- Uncomplicated alcohol and sedative/hypnotic detoxification can generally be accomplished in 2-3 days in an inpatient setting, while more complex detoxification may require 3-5 days.
- Uncomplicated opiate detoxification can generally be accomplished in 3-6 days in an inpatient setting.

■ Refer to **acute inpatient dual diagnosis treatment**, when there is evidence for immediate behavioral safety risk with emergence of a more complex acute psychiatric picture or potential safety risks of psychiatric complications associated with severe impairment in relationships and social role performance. These services can also be employed in case of the acute emergence of a suspected Substance-Induced Mental Disorder.

■ Refer to **acute inpatient rehabilitation programs** when SUD is severe enough to markedly interfere with daily functioning, the patient is not in acute withdrawal, **and** there is medical or psychiatric co-morbidity that would interfere with treatment.

■ Refer to **residential treatment** (if covered by benefit structure) when the pattern of SUD is

- severe enough to markedly interfere with functioning and active use could not be stopped outside of a contained environment
- there is no need for acute detoxification
- there is documented evidence of treatment failure at Partial Hospitalization or structured Intensive Outpatient SUD treatment programs despite evidence of active and consistent participation
- history is suggestive that there is a high likelihood of imminent relapse that would place the patient at serious risk of harm if treated in a less restrictive setting (e.g., no impulse control, comorbid psychiatric complications).

■ Refer to **partial hospital treatment** when SUD markedly interferes with functioning **and** the patient needs daily structured treatment and medical supervision for 4 or more hours daily and there is otherwise a home environment that is supportive and conducive to recovery.

■ Refer to a **structured intensive outpatient program** when there is significant interference with functioning, no need for acute

detoxification, and the patient requires structured intervention for up to 3 hours a day and the recovery environment is sufficiently supportive not to require a higher level of care.

■ Individual or group **outpatient treatment** by a therapist credentialed or experienced in SUD treatment using established protocols can be effective if the therapist focuses on abstinence and recovery, incorporates educational techniques and motivational enhancement and promotes active participation in community self-help, MHGs and TSF or other proven forms of recovery.

■ **Brief intervention** is effective for patients who abuse substances, but are not substance dependent. Several brief intervention approaches have been identified, including relapse-prevention groups, self-efficacy, motivational enhancement, collaborative, solution-focused, cognitive behavioral, strategic counseling approaches or Internet-based videoconferencing. All share such characteristics as using the simplest, most immediate intervention, integrating the diagnostic process into the intervention activity, and connecting the patient with needed resources including community self-help groups. Emerging technologies are being put to use, such as Alcohol-Comprehensive Health Enhancement Support System (A-CHES), which uses smartphones to provide information, adherence strategies, decision-making tools, reminders, and social support services in easy -to-use format, and can be downloaded as a smartphone application <https://www.chess.health/>

*Recovery from substance use disorders is a long-term process and frequently involves multiples episodes of treatment.*

*Critical elements of treatment include:*



■ The **goal of treatment is abstinence** from all substances of abuse.

■ A strong **therapeutic alliance** is an important factor in achieving successful treatment.

■ **Motivating the client** to seek and/or continue treatment. Make every effort to ensure that patients with SUD:

- **Initiate** treatment: Receive a second addiction-related outpatient service within 3-14 days of an initial assessment
- **Engage** in treatment: Receive at least 2 or more addiction-related services within 30 days of initiation of discharge from substance related inpatient admission

■ **Developing and facilitating adherence** to a highly individualized treatment plan that addresses relapse and emphasizes available preventive mechanisms. **Individual patients should be encouraged to take full responsibility and ownership of their treatment plan.** An individual's treatment plan must be assessed continually and modified as necessary to ensure that it meets the person's changing needs. To this end, treatment facilities should encourage patients to complete daily written recovery assignments that are tailored onto their specific life issues and stress triggers. There should be concerted efforts devoted to seeking and securing adequate sober living arrangements from the beginning of treatment and aftercare

plans should be developed and adjusted all throughout treatment.

- Identification of comorbid medical conditions with referral to appropriate treatment providers while encouraging coordination of care.

- Treatment for comorbid psychiatric conditions (dual diagnosis) while encouraging coordination of care.

- Education about the causes and course of SUD, the need for abstinence, relapse triggers, available treatments, and role of family and friends.

- Relapse prevention strategies.

- Family education and counseling and referral to self-help community support groups for family members.

- Coordination of treatment with other healthcare providers, the legal system, EAP and other resources as appropriate.

- Referral to community resources such as self-help groups or MHGs.

- Consideration of referral for family treatment to deal with effects of substance abuse.

- Follow-up after discharge from treatment at each level of care to encourage consistency with treatment plan recommendations.

- Research on addiction indicates that, in general, adequate participation in treatment is essential to effectiveness and longer participation in recovery programs leads to better outcomes.

## Specific treatments:

### Pharmacological treatments (evidence-based)

- Medications to treat intoxication and withdrawal states; Medications used primarily to treat intoxication and withdrawal states will require consistent use of withdrawal measuring scales (CIWA-Ar, CIWA-B, COWS) to evaluate severity of withdrawal signs and symptoms and determine appropriate taper of substitution meds:

#### Opioid Detox Protocols

- a. Using opioid substitution:
  - Buprenorphine
  - Methadone
  - Other opioids
- b. Using clonidine

#### Alcohol Detox Protocols:

- a. Using benzodiazepine substitution



- b. Using phenobarbital substitution
  - c. Using anticonvulsants meds (gabapentin, carbamazepine)
- Sedative-Hypnotics Detox Protocols:
- a. Using phenobarbital substitution
  - b. Using clonazepam substitution
  - c. Using other benzodiazepine substitution.
- Medications to decrease urges or cravings of abused substances:
    - Alcohol
      - Acamprosate: 666mg TID; this should be offered as part of the SUD treatment recommendation to all alcoholic patients reporting cravings >3/10 as soon as they have completed Detox and throughout their SUD treatment stages for as long as they experience cravings.
  - Medications to decrease the reinforcing effects of abused substances:
    - Alcohol
      - Naltrexone: usual daily dose is 50mg; this should be offered as part of the SUD treatment recommendation to all alcoholic patients reporting ongoing cravings and showing early recovery impaired coping skills, living and or working in triggering settings and longing for the alcohol high.
      - Naltrexone depot IM (Vivitrol): 380mg IM every 4 weeks; this should be offered to the same patients as noted above after they have shown good tolerance to Naltrexone PO and continue to be considered at high risk for relapse.
    - Opiates
      - Naltrexone: must be opioid free 5-7 days; this should be offered as part of the SUD treatment recommendation to all opioid use disorder patients reporting ongoing cravings and showing early recovery impaired coping skills, living and or working in triggering settings and longing for the opioid high.
      - Naltrexone depot IM (Vivitrol): 380mg IM every 4 weeks; this should be offered to the same patients as noted above after they have shown good tolerance to Naltrexone PO and continue to be considered at high risk for relapse.
  - Agonist or mixed agonist/ antagonist maintenance therapies:
    - Opiates
      - Methadone: 40mg/day – 60mg/day (sometimes even less) of methadone is usually sufficient to block opioid withdrawal symptoms. Higher doses (80-120mg/ day) have been shown to curb dramatically additional use of opioids.
      - Buprenorphine: used only in an inpatient or controlled setting
      - Buprenorphine/naloxone combination (ranging between 4mg/0.5mg – 32mg/8mg per day, sublingual in divided doses). Doses used more frequently in the outpatient ambulatory setting include 16mg/4mg per day sublingual or less and typically require monthly visits for renewal as well as continued participation in SUD treatment or recovery community support systems
      - Buprenorphine long acting injectable (Sublocade) over age 18, after dosing 8 to 24 mg/day of buprenorphine for at least 7 days, IM dose does not exceed 300 mg per month
      - Buprenorphine (Probuphine) Implant: over age 16, in patients able to maintain (low or no cravings) on a maintenance dose of ≤ 8 mg/day of oral buprenorphine, dose does not exceed 4 implants/6 months duration.
  - Abstinence-promoting and relapse prevention therapies:

- Alcohol
  - Disulfiram: usual dose 250mg/day, rarely: 125mg/day – 500mg/day (potentially aversive if used with alcohol). This medication can be helpful in those patients who have a track record consistent with frequent relapse and inability to maintain abstinence for an extended period of time. Breathalyzer testing to assure compliance and continued abstinence and liver function tests should be checked periodically.

### Evaluating Pain Patients for Risk of Opioid Abuse or Dependence and Pain Management Treatment Recommendations

- Refer patient to a Pain Management Specialist, if available
- Use the concept of “universal precautions,” implying that any patient in pain could develop a drug misuse problem
- Use Tools for Patient Risk Assessment such as Opioid Risk Tool (ORT) or Screener and Opioid Assessment for Patients with Pain (SOAPP-R), links in the reference section below
- Use written agreements encompassing the full range of patient’s care, starting with assessments, informed consent (including benefits and risks, clarifying the physician’s and patient’s realistic expectations, roles and responsibilities, treatment termination contingencies), treatment plan, and outlined best practices in working out a clear understanding of how treatment works, that should be preferably shared with the patient, the patient’s family and other clinicians involved in the patient’s care. Opioid treatment agreements are a standard of care when prescribing long-term opioid therapy.
- Creating Function-based Realistic Measurable Goals Opioid Treatment Plans
- Follow the FDA Blueprint for Prescriber Education to refresh latest knowledge on opioid products and drug interactions (<http://www.er-la-opioidrems.com>)
- Build into the treatment protocol periodic Progress Review against the agreed Goals and Monitor Adherence (including drug testing where possible) and use Prescription Drug Monitoring Programs where available.

### Psychosocial Treatments

- Cognitive-behavioral therapies (e.g. relapse prevention, social skills training)
- Motivational Enhancement Therapy (MET is a short term intervention, usually 3-5 sessions as per the Patient Placement Criteria 2-Revision (PPC-2R), and it is not a general method of trying to convince someone to engage.
- Behavioral therapies (e.g. community reinforcement, contingency management)
- Group therapy
- Twelve-step facilitation
- Interpersonal therapy
- Family/Marital therapy
- Brief therapies (A-FRAMES model)
  - **A**ssessment
  - Providing objective **F**eedback
  - Emphasizing that the **R**esponsibility for change belongs to the patient
  - Giving clear **A**dvice about the benefits of change
  - Providing a **M**enu of options for treatment
  - Using **E**mpathic listening
  - Emphasizing and encouraging **S**elf-efficacy
- Self-guided therapies (for heavy users of legal substances who do not yet meet criteria for an SUD)
  - Manual-guided self-help programs
  - Manual-guided therapies with a clinician

- Computer-guided programs on the Internet
- Internet-based videoconferencing
  - Allows patients to participate from their own homes
  - Manual-guided therapies with a clinician
  - Preferred due to convenience and increased confidentiality

## **Tobacco Use Disorder**

- Tobacco use is common in patients with other substance use and psychiatric disorders, as well as medical conditions
- Clinicians in all treatment settings should identify smokers and smokeless tobacco users and be prepared to offer them motivational interventions to encourage them to quit
- Patients who are hospitalized in smoke-free environments need to be
  - assessed and treated for tobacco withdrawal
  - provided education about the rationale for the smoke-free unit
  - educated about the goal of smoking cessation and, if the patient is interested, helped to begin a cessation program
- Assessment should include
  - The current level of tobacco use (e.g., number of cigarettes per day)
  - The degree of nicotine dependence (consider using the CAGE and the Fagerstrom Test for Nicotine Dependence to establish this)  
<http://www.aafp.org/afp/20000801/579.html>
  - The patient's motivation(s) for quitting
  - Questions about past attempts to quite, duration of any periods of abstinence, factors that undermined abstinence, the patient's fears about quitting (e.g., weight gain, another failure) and barriers to another attempt
- The treatment of Tobacco Use Disorders differs from that of other substance dependencies in several ways:
  - A specific "quit date" is usually set in advance of stopping use
  - Nicotine-dependent patients generally do not experience substantial occupational problems due to use
  - There is a decreased need for family involvement, unless there are other smokers in the home
  - Effective over-the-counter medication treatments are available
- Pharmacological treatments
  - Should be offered to all patients who wish to stop smoking
  - Are often effective even when no psychosocial treatment is provided
  - Include
    - Nicotine replacement therapy, or NRT: gum, patch, lozenge, nasal spray, inhaler
    - Bupropion: 150 mg/day starting one week prior to quit date, increase to 150 mg bid after 3-4 days
    - Varenicline: 0.5 mg days 1-3, 0,5 mg bid days 4-7, then I mg/day for 12 weeks<sup>7</sup>
- Psychosocial treatments
  - Social support (spouse, partner, buddy system) is recommended
  - Brief therapies such as behavioral supportive cessation counseling
    - Include elements of Motivational Enhancement Therapy
    - Encourage patients to examine reasons for and against quitting tobacco use
    - Can be successfully and economically implemented in a broad range of healthcare settings

- May lead to a greater likelihood of success in smoking cessation
- Behavioral therapies
- Cognitive-behavioral therapies, particularly for patients with comorbid depressive symptoms, Major Depression and other substance use disorders
- Self-guided therapies such as those mentioned in the previous section as well as
  - Community support groups
  - Telephonic counseling
- The use of multiple modes of therapy such as written materials plus phone contact improves the effectiveness of self-help methods
- There is insufficient data to support the use of 12-step programs, hypnosis, biofeedback, family therapy, interpersonal therapy and psychodynamic therapies in the treatment of nicotine dependence

### **Resources for Patients:**

- National Institute on Drug Abuse  
<http://www.drugabuse.gov/Infofacts/Infofaxindex.html>
- National Institute on Alcohol Abuse and Alcoholism: <http://www.niaaa.nih.gov/>
- American Lung Association Freedom from Smoking Program:  
<http://www.freedomfromsmoking.org/>
- Self-help groups can be located via the Internet or by looking in the telephone book. There are Twelve Step programs for alcoholics as well as specific groups for those who use marijuana, cocaine or narcotics. These should be searched for using the specific substance for which self-help is being sought (e.g. "alcoholics anonymous" or "narcotics anonymous"). In addition to Twelve Step programs, there are other non-twelve step groups such as Women for Sobriety, Secular Organizations for Sobriety (SOS) and Self-Management and Recovery Training (SMART) for those individual for whom the Twelve Step approach is not appropriate. It should be noted, however, that the non-Twelve Step programs are not nearly as widely available as their Twelve-Step counterparts.

### **Web Resources for Professionals:**

- SAMHSA: <https://www.samhsa.gov/medication-assisted-treatment>
- Opiate Risk Tool (ORT):  
<https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf>
- FDA Opioid Blueprint for Prescriber Education: <http://www.er-la-opioidrems.com>
- American Academy of Pain Medicine: [www.painmed.org](http://www.painmed.org)
- National Institute of Drug Abuse  
<https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>
- Centers for Disease Control and Prevention: NCHS Data Brief. Drug-poisonings Deaths Involving Opioid Analgesics: United States 1999-2011.  
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- American Psychiatric Association Practice Guidelines:  
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- American Psychiatric Association Practice Guidelines: Guideline Watch: Practice Guideline for the Treatment of Patients With Substance Use Disorders, 2nd Edition Updates, 2007  
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- DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale at  
<http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2013.12060782?journalCode=ajp>

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## Important Notice

### **General Purpose.**

Health Medical Policies (the 'Policies') are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the members contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The members contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps.

### **Policy Effective Date and Defined Terms.**

The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

### **Policy Amendment without Notice.**

Health Net reserves the right to amend the Policies without notice to providers or Members.

### **No Medical Advice.**

The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

### **No Authorization or Guarantee of Coverage.**

The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

### **Policy Limitation: Member's Contract Controls Coverage Determinations.**

The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member's contract, and requirements of applicable laws and regulations. The contract language contains specific terms and conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Members contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Members contract shall govern. Coverage decisions are the result of the terms and conditions of the Members benefit contract. The Policies do not replace or amend the Members contract. If there is a discrepancy between the Policies and the Member's contract, the Member's contract shall govern.

### **Policy Limitation: Legal and Regulatory Mandates and Requirements**

The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

### **Policy Limitations: Medicare and Medicaid**

Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.