Ultra-Rapid Detoxification

MEDICAL POLICY NUMBER: 258

Effective Date: 11/1/2026

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INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Note: This policy does not apply to detoxification or emergency detoxification, which may be considered medically necessary.

Ultra-rapid detoxification is considered **not medically necessary** for the treatment of any indication, including but not limited to, withdrawal from opioid dependence.

Link to Evidence Summary

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

BACKGROUND

Ultra-Rapid Detoxification

Ultra-rapid detoxification (UROD) refers to the use of general anesthesia alongside high doses of an opiate antagonist (naloxone). The procedure is performed in an intensive care unit and the patient

requires 1 to 2 days of hospitalization. The procedure hypothetically accelerates detoxification and eliminates dependency, while shielding the patient from withdrawal symptoms.

Opioid Withdrawal

Opioid withdrawal refers to a host of symptoms that may occur when an opioid-dependent individual stops using opioids. These may include drug craving, anxiety, restlessness, gastrointestinal distress, diaphoresis, and tachycardia.[1]

Detoxification

Medically-supervised opioid withdrawal, also known as detoxification, involves the administration of medication to reduce the severity of withdrawal symptoms.[1] Medications used in the treatment of withdrawal symptoms may include opioid agonists such as methadone and buprenorphine (a partial agonist), as well as alpha-2 adrenergic agonists such as clonidine and lofexidine.[1]

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

EVIDENCE REVIEW

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of ultrarapid detoxification. Below is a summary of the available evidence identified through August 2026.

Systematic Reviews

In 2010, Gowing and colleagues conducted a systematic review addressing the safety and efficacy of opioid antagonists under heavy sedation or anesthesia (i.e. ultra-rapid detoxification for the treatment of opioid withdrawal.[2] Independent investigators systematically searched the literature through August 2009, identified eligible studies, assessed study quality and extracted data. In total, 9 studies (8 RCTs) reporting data from 1,109 participants were included for review. Primary outcomes of interest include intensity of withdrawal, duration of treatment, nature and incidence of adverse events and completion of withdrawal treatment. Authors found that antagonist-induced withdrawal was more intense but less prolonged than withdrawal managed with reducing doses of methadone, and that doses of naltrexone sufficient for blockade of opioid effects can be established significantly more quickly with antagonist-induced withdrawal than withdrawal managed with clonidine and symptomatic medications. Nonetheless, data indicated a significantly greater risk of adverse events with heavy, compared to light, sedation (RR 3.21, 95% CI 1.13 to 9.12, p = 0.03). Investigators concluded that antagonist-induced

withdrawal under heavy sedation or anaesthesia is not supported and does not confer additional benefits in terms of less severe withdrawal or increased rates of commencement on maintenance treatment.

Nonrandomized Studies

In addition to studies included in the systematic review above,[2] several recent clinical trials assessed the safety and efficacy of ultra-rapid detoxification.[3-6] Results from large samples (n= 64-424) reported mixed results at short-term follow-up, and high relapse rates among patients receiving UROD alone at short- and intermediate-follow-up, potentially due to a lack of accompanying maintenance therapy and social support.[1,4]

CLINICAL PRACTICE GUIDELINES

Centers for Disease Control and Prevention

In 2022, the Centers for Disease Control and Prevention recommended against ultra-rapid detoxification in its for prescribing opioids for chronic pain.[7] Authors stated that "ultrarapid detoxification under anesthesia is associated with substantial risks, including death, and should not be used."[7]

Canadian Agency for Drugs and Technologies in Health (CADTH)

In 2016, the CADTH published a guideline recommended against the use of UROD, due to high risk for adverse events and limited evidence of efficacy.[8]

American Society of Addiction Medicine (ASAM)

In 2020, the ASAM published a national practice guideline for the use of medications in the treatment of addiction involving opioid use.[9] Authors recommended against the use of UROD in the treatment of opioid withdrawal.

World Federation of Societies of Biological Psychiatry (WFSBP)

In 2011, the WFSBP published guidelines addressing the biological treatment of opioid dependence.[10] Authors recommended against UROD citing safety and efficacy concerns.

National Institutes for Health and Care Excellence (NICE)

In 2007, the NICE published a clinical practice guideline addressing drug misuse and opioid detoxification in adults.[11] Authors recommended against UROD citing the risk of serious adverse events, including death.

EVIDENCE SUMMARY

Evidence is insufficient to support the efficacy of ultra-rapid detoxification (UROD) for the treatment of opioid dependence withdrawal. There is a lack of well-designed controlled trials, and studies to date have reported high relapse rates among patients undergoing UROD relative to other treatments.

Moreover, all clinical practice organizations that address UROD recommend against its use due to the treatment's elevated risk of adverse events, including death.

HEALTH EQUITY CONSIDERATIONS

The Centers for Disease Control and Prevention (CDC) defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving health equity requires addressing health disparities and social determinants of health. A health disparity is the occurrence of diseases at greater levels among certain population groups more than among others. Health disparities are linked to social determinants of health which are non-medical factors that influence health outcomes such as the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. Social determinants of health include unequal access to health care, lack of education, poverty, stigma, and racism.

The U.S. Department of Health and Human Services Office of Minority Health calls out unique areas where health disparities are noted based on race and ethnicity. Providence Health Plan (PHP) regularly reviews these areas of opportunity to see if any changes can be made to our medical or pharmacy policies to support our members obtaining their highest level of health. Upon review, PHP creates a Coverage Recommendation (CORE) form detailing which groups are impacted by the disparity, the research surrounding the disparity, and recommendations from professional organizations. PHP Health Equity COREs are updated regularly and can be found online here.

BILLING GUIDELINES AND CODING

CODES*		
CPT	90899	Unlisted psychiatric service or procedure

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. UpToDate. Medically supervised opioid withdrawal during treatment for addiction. https://www.uptodate.com/contents/medically-supervised-opioid-withdrawal-during-treatment-for-addiction. Published 2026. Accessed 9/17/2026.
2. Gowing L, Ali R, White JM. Opioid antagonists under heavy sedation or anaesthesia for opioid withdrawal. *Cochrane Database of Systematic Reviews.* 2010(1).
3. Qiu Y-w, Jiang G-h, Su H-h, et al. Short-term UROD treatment on cerebral function in codeine-containing cough syrups dependent male individuals. *European radiology.* 2016;26(9):2964-2973.
4. Salimi A, Safari F, Mohajerani SA, Hashemian M, Kolahi A-A, Mottaghi K. Long-term relapse of ultra-rapid opioid detoxification. *Journal of addictive diseases.* 2014;33(1):33-40.
5. Forozeshfard M, Zoroufchi BH, Zafarghandi MBS, Bandari R, Foroutan B. Six-month follow-up study of ultrarapid opiate detoxification with naltrexone. *International journal of high risk behaviors & addiction.* 2014;3(4).
6. Safari F, Mottaghi K, Malek S, Salimi A. Effect of ultra-rapid opiate detoxification on withdrawal syndrome. *Journal of addictive diseases.* 2010;29(4):449-454.
7. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report: CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2022. https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm. Accessed 9/17/2026.
8. Canadian Agency for Drugs and Technologies in Health. Rapid and Ultra-Rapid Detoxification in Adults with Opioid Addiction: A Review of Clinical and Cost-Effectiveness, Safety, and Guidelines. Jan 15, 2016. https://www.ncbi.nlm.nih.gov/books/NBK343899/pdf/Bookshelf_NBK343899.pdf. Accessed 9/17/2026.
9. American Society of Addiction Medicine. The National Practice Guideline - For the Use of Medications in the Treatment of Addiction Involving Opioid Use. 2020 Focused Update. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2. Accessed 9/17/2026.
10. Soyka M, Kranzler HR, van den Brink W, et al. The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of substance use and related disorders. Part 2: Opioid dependence. *The world journal of biological psychiatry.* 2011;12(3):160-187.
11. National Institutes for Health and Care Excellence. Drug misuse in over 16s: opioid detoxification. July 25 2007. https://www.nice.org.uk/guidance/cg52/chapter/1-Guidance. Accessed 9/17/2026.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Converted to new policy template.
11/2023	Annual update. No changes to criteria.
11/2024	Annual update. No changes to criteria.
11/2025	Annual update. No changes to criteria.
11/2026	Annual update. No changes to criteria.