The National Survey on Drug Use and Health (NSDUH) for 2005 found that within the month prior to survey among Americans age 12 and over 6.6% (16 million people) reported heavy drinking, 34.6% (84 million people) were current tobacco users and 8.1% (19.7 million people) used illicit substances. National Institute of Alcohol Abuse and Alcoholism (NIAAA) released data from a 2012 survey of Americans 18 and older showing that 29% of women and 43% of men reported at least one episode of binge drinking (4+ drinks for women/ 5+ for men within 2 hours). 8% of men and 2.5% of women surveyed drank daily. Alcohol is the third-leading risk factor for premature death and disability globally, according to data from NIAA. Costs associated with just alcohol abuse in the US were $223.5 billion in 2006. More than 70% of total costs were attributed to lost productivity. It is estimated that 15% of the U.S. workforce or about 19.2 million workers consume enough alcohol to lead to workplace impairment and 9% of them reported heavy use (defined as 5 or more drinks on same occasion on 5 or more days in the past 30 days). 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. 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). Drug overdose is now the second-leading cause of accidental death in America, exceeded only by car crashes. 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 maladaptive pattern of substance use leading at the minimum to *clinically significant impairment or distress*, as manifested by at least one of the following:

<table>
<thead>
<tr>
<th>For substance abuse, diagnostic criteria include one or more:</th>
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<tbody>
<tr>
<td>■ Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home.</td>
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<tr>
<td>■ Recurrent substance use in situations in which it is physically hazardous.</td>
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<tr>
<td>■ Recurrent substance-related legal problems.</td>
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<tr>
<td>■ Continued substance use despite persistent or recurrent social or interpersonal problems related to the substance.</td>
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</table>

**Substance Dependence**

*Substance dependence* is defined as a maladaptive pattern of substance use disorder, leading to *cognitive, behavioral and physiological significant impairment or distress*, manifested by at least three of the following:
**For substance dependence, diagnostic criteria include at least three:**

- **Tolerance** – either need for increased amounts of a given chemical substance or substances within the same group to achieve desired effect or resulting in markedly diminished effect if the same amount is used.

- **Withdrawal** – a symptom cluster either 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.

- Patient takes the substance in larger amounts or longer than originally intended.

- Patient displays a persistent desire to use, or an unsuccessful effort to control use of a specific substance.

- Great deal of time is spent obtaining, using or recovering from use of the substance.

- Important activities are given up or reduced because of substance use.

- Substance use is continued despite knowing problems are caused by substance.

- Social impairment: Failure to fulfill major role obligations (home, work, school). Healthier social activities are replaced with substance use related activities.

- Failure to abstain from using substances despite awareness of the difficulties it is causing.

**Substance-Induced Disorders** includes **Intoxication, Withdrawal** and **Other Substance-Induced Mental Disorders**.

**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.

**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.

**Substance-Induced Mental Disorder:** Potentially severe, usually temporary, but sometimes persisting CNS syndrome developing in the context of substance use.

- Clinically significant symptomatic presentation of a relevant mental disorder.

- Disorder developed within one month of exposure to a substance capable of producing a mental disorder,

- Disorder cannot be explained by an independent mental disorder

- 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)
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.

- 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 in the new NIH studies, such as Alcohol-Comprehensive Health Enhancement Support System (A-CHESS), 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 (http://www.highbeam.com/doc/1G1-255840782.html).

Recovery from substance use disorders is a long-term process and frequently involves multiple 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 to decrease urges or cravings of abused substances:
  - Alcohol
    - Acamprosate: 666mg TID;
- Medications to decrease the reinforcing effects of abused substances:
  - Alcohol
    - Naltrexone: usual daily dose is 50mg;
    - Naltrexone IM (Vivitrol): 380mg IM every 4 weeks;
  - Opiates
    - Naltrexone: must be opioid free 5-7 days.
    - Naltrexone IM (Vivitrol): 380mg IM every 4 weeks;
- Agonist maintenance therapies:
  - Opiates
    - Methadone: 40mg/day – 60mg/day (sometimes even less) of methadone is usually sufficient to block opioid withdrawal symptoms.
    - 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).
- Abstinence-promoting and relapse prevention therapies:
  - Alcohol
    - Disulfiram: usual dose 250mg/day, rarely: 125mg/day – 500mg/day (potentially aversive if used with alcohol).

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. Samples of such agreements are available at http://opioids911.org/media/doc/OpioidRxAgreements.doc
• 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)
  ➢ Assessment
  ➢ Providing objective Feedback
  ➢ Emphasizing that the Responsibility for change belongs to the patient
  ➢ Giving clear Advice about the benefits of change
  ➢ Providing a Menu of options for treatment
  ➢ Using Empathic listening
  ➢ Emphasizing and encouraging Self-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

Nicotine Dependence
Nicotine dependence 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 nicotine 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 quit, 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 nicotine dependence differs from that of other substance dependencies in several ways:
- Pharmacotherapies are highly effective
- 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 1 mg/day for 12 weeks

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://ffsonline.org/
- Patient Counseling Document on Extended-Release Long-Acting Opioid Analgesics:
- 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: http://kap.samhsa.gov/products/brochures/pdfs/Pocket_2.pdf
- MAST, CAGE, DAST, CRAFFT, AUDIT, TWEAK, Fagerstrom Test for Nicotine Dependence:
  http://www.projectcork.org/clinical_tools/
- Opiate Risk Tool (ORT): http://www.opioidrisk.com/node/887
- Screener and Opioid Assessment for Patients with Pain, version I, Revised (SOAPP-R):
  http://www.inflexxion.com/SOAPP/
- Opioid Treatment Agreement Samples: http://opioids911.org/media/doc/Op911-OpioidRxAgreements.doc
- FDA Opioid Blueprint for Prescriber Education: http://www.er-la-opioidrems.com
- American Academy of Pain Medicine: painmed.org
  http://www.cdc.gov/nchs/data/databriefs/db166.htm
- American Psychiatric Association Practice Guidelines:
  http://ps.psychiatryonline.org/doi/abs/10.1176/ps.46.11.1202
  http://focus.psychiatryonline.org/doi/abs/10.1176/foc.5.2.foc163?journalCode=foc
- DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale at

Review History

National Medical Policy Committee November, 2005
MHN Clinical Policy Committee  February 13, 2007
Health Net Medical Advisory Council  March 2007
MHN Clinical Policy Committee  February 10, 2009
Health Net Medical Advisory Council  March, 2009
MHN Clinical Leadership Committee  February 3, 2011
Health Net Medical Advisory Council  February 9, 2011
MHN QI/UM Committee  December, 2012
Health Net Medical Advisory Council  February 2013
MHN QI/UM Committee  December, 2013
Health Net Medical Advisory Council  February, 2014
MHN QI/UM Committee  December, 2014
Health Net Medical Advisory Council  February, 2015
MHN QI/UM Committee  December, 2015
Health Net Medical Advisory Council  February, 2016

References
1. Results from the 2005 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies

Additional References
6. NIDA NOTES. Adolescent Treatment Programs reduce drug abuse, produce others improvements, 17(1), 2002.


Important Notice

General Purpose.
Health Net’s National 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 member’s 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 member’s 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 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 Member’s contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member’s contract shall govern. Coverage decisions are the result of the terms and conditions of the Member’s benefit contract. The Policies do not replace or amend the Member’s 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.