Subject: **Drug and Alcohol Detoxification***

Effective Date: **September 29, 2015**

Department(s): **Utilization Management**

Policy: Acute inpatient and ambulatory drug and alcohol detoxification services are reimbursable under plans administered by QualCare, Inc. when medical necessity criteria delineated in this policy are met.

Objective: To provide proper and consistent reimbursement and to define the indications for admission to and continued stay at the acute inpatient level of care for drug and alcohol detoxification.

Procedure: **I. Acute Inpatient Drug and Alcohol detoxification**

Medical documentation should support that all of the following services are needed:

- Round-the-clock intensive, psychiatric/medical, and nursing care, including continuous observation and monitoring.
- Appropriate medical professionals are available, including physician visits at least once each day and 24-hour nursing staff monitoring.
- Daily monitoring of psychiatric medication effects and side effects, and
- A contained environment for specific treatments that could not be safely done in a non-monitored setting.

as evidenced by the following admission or continued stay criteria being met:

A. **Admission -** all of the following:

1. There is a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, with presenting signs and symptoms requiring active treatment that can only be safely and effectively provided in a 24 hour per day setting with nursing care and daily medical interventions.

2. The individual is at risk for a severe withdrawal syndrome as evidenced by abnormal vital signs (blood pressure, temperature, pulse, and respirations), clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), and **one or more** of the following:

   2a. Severe Alcohol and/or Sedative-Hypnotic Withdrawal as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting, clouding of sensorium, delirium, seizures, and/or hallucinations.

   2b. Severe Opiate Withdrawal as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, sweating, diarrhea, dilated pupils, irritability, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, and/or yawning.

   2c. Prior complicated and potentially life-threatening withdrawal with a history of seizures, delirium tremens, or hallucinations associated with alcohol and/or sedative-hypnotic use or withdrawal.

3. In lieu of criteria 2a, b or c above, the individual is currently suffering from symptoms of a severe mental illness or has such irrational or bizarre thinking that he/she could not be safely treated in a less intensive level of care.

NOTE: This level of care is not justified by simple intoxication or fear of withdrawal. Therefore, elevated blood alcohol level without any associated withdrawal symptoms is not enough to justify detoxification treatment.

It is recognized that life threatening intoxication/poisoning (i.e. endangering vital functions - central nervous system, cardiac, respiratory) may need acute medical attention, but that attention is generally not considered detoxification. In such cases, treatment at a medical/surgical unit may be needed and medical necessity criteria are applied when the individual has acute and severe medical problems such as acute onset of seizures, severe electrolyte imbalance, gastrointestinal bleeds, cardiac complications, acute liver failure, or the underlying substance abuse is of such severity that it will likely cause severe and acute medical complications in the near future requiring acute medical management.

B. **Continued stay** at inpatient detoxification level of care

One or more of the following criteria must be met:

1. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care, **OR**
2. If the treatment plan implemented is not leading to measurable clinical improvements and the individual continues to suffer from severe withdrawal symptoms that require active treatment efforts that can only be provided by around-the-clock intensive nursing care and daily monitoring by a physician. There must be ongoing reassessment and modifications to the treatment plan that

address specific barriers to achieving improvement, when clinically indicated, **OR**

3. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

AND, ALL of the following:

4. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.
5. Continued stay is not primarily for the purpose of providing a safe and structured environment.
6. Continued stay is not primarily due to a lack of external supports.

II. Ambulatory Drug and Alcohol Detoxification

Medical documentation should support that the following services are needed: a time-limited level of intervention for medical monitoring of mild to moderate withdrawal symptoms, with daily monitoring by nursing staff and availability of appropriate medical professionals which may include a psychiatrist or an addictionologist to ensure a safe and effective withdrawal from alcohol, sedative-hypnotic medications or opiates for individuals who can maintain personal safety with support systems in the community, as evidenced by the following admission or continued stay criteria being met:

A. **Admission**-All of the following must be met:

1. The individual has a documented diagnosis of a moderate-to-severe substance use disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

2. The individual is at risk for a withdrawal syndrome as evidenced by abnormal vital signs (blood pressure, temperature, pulse, and respirations), clinically-based scales such as Clinical Institute Withdrawal Assessment (CIWA) or Clinical Opiate Withdrawal Scale (COWS), and one or more of the following:

    a. Alcohol and/or Sedative-Hypnotic Withdrawal as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: agitation, tremor, sweating, diarrhea, headache, nausea and vomiting,

OR

b. Opiate withdrawal as evidenced by recent use of these substances AND some or all of the following observable, objective symptoms: irritability, lack of appetite, sweating, diarrhea, dilated pupils, insomnia, teary eyes, muscle spasms, erection of the hair on the skin, runny nose, rapid breathing, yawning

AND

3. The presenting signs/symptoms must be causing clinically significant distress or impairment of social, occupational, or other important area of functioning

AND

4. The individual does not require around-the-clock nursing care.

AND

5. When there is a history of repeated relapses and/or multiple failed treatment episodes, the individual is demonstrating a commitment to actively engage in the implementation of a treatment plan that:

-Includes clear interventions specifically addressing prior non-adherence and poor response to treatment

- Includes clear interventions that are likely to reduce the frequency and severity of future relapse

- Has the goal of maintaining abstinence.

B. **Continued Stay**

1. One or more of the following criteria must be met:

A. The treatment provided is leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care,

OR

B. If the treatment plan implemented is not leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, there must be ongoing reassessment and, modification to the treatment plan that addresses specific barriers to achieving improvement, when clinically indicated,

OR

C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.

AND

2. All of the following must be met:

a. The individual and family are involved to the best of their ability in the treatment and discharge planning process, unless there is a documented clinical contraindication.

b. Continued stay is not primarily for the purpose of providing a safe and structured environment.

c. Continued stay is not primarily due to a lack of external supports.

Note: A Discharge Plan that starts at the time of admission and includes:

- At least weekly assessment of progress towards goals and status of aftercare plans
- Coordination with family, outpatient providers, and community resources to allow a smooth transition to less restrictive levels of care.
- Timely and clinically appropriate aftercare appointments
- A prescription for any prescribed medications sufficient to bridge the time between discharge and the scheduled follow-up psychiatric appointment.

References

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Revised By/Date: MMcNeil, MD 06/02/17
Approved By/Date: QM Committee 6/20/17

*Consistent with Summary Plan Description (SPD). When there is discordance between this policy and the SPD, the provisions of the SPD prevail.