IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Inpatient Detoxification	**Guideline #**	UM_OTH 04
		Original Effective Date	2/25/2009
Section	Other	**Revision Date**	5/9/2018

COVERAGE POLICY

Inpatient detoxification is covered only when the inpatient admission is primarily due to an underlying medical condition, which requires 24-hour monitoring in an acute care setting. There must be a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition necessitating the highest level of physician preparedness to intervene urgently with inpatient acute care services needed for life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate, these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition.

Members seeking the Medi-Cal fee for service (FFS) benefit for voluntary inpatient detoxification (VID) are to be referred to a VID provider in a general acute care hospital. To access the FFS VID benefit, the primary reason for the voluntary inpatient admission is for inpatient detoxification. Members who do not meet the FFS VID criteria outlined below should be provided with medically necessary referrals to the county's behavioral health department for medically necessary substance use disorder (SUD) treatment services. IEHP must provide care coordination to ensure Members receive appropriate referrals to county services.

Medical criteria for inpatient admission for the FFS VID benefit must include one or more of the following:

1. Delirium tremens, with any combination of the following clinical manifestations with cessation or reduced intake of alcohol/sedative.
    a. Hallucinations
    b. Disorientation
    c. Tachycardia
    d. Hypertension
    e. Fever
    f. Agitation; or
    g. Diaphoresis
2. Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) form score greater than 15.
3. Alcohol/sedative withdrawal with CIWA score greater than 8 *and* one or more of the following high-risk factors:
    a. Multiple substance abuse
    b. History of delirium tremens

c. Unable to receive the necessary medical assessment, monitoring, and treatment in a setting with a lower level of care
d. Medical co-morbidities that make detoxification in an outpatient setting unsafe
e. History of failed outpatient treatment
f. Psychiatric co-morbidities
g. Pregnancy; or
h. History of seizure disorder or withdrawal seizures

4. Complications of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following factors:
    a. Persistent vomiting and diarrhea from opioid withdrawal; and
    b. Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care.

COVERAGE LIMITATIONS AND EXCLUSIONS

Examples of covered services:

1. Delirium tremens associated with withdrawal of alcohol/sedative complicated by seizure and altered mental status or pregnancy.
2. Opioid withdrawal associated with refractory nausea/vomiting/diarrhea.

Examples of non-covered services:

1. Non life threatening symptoms in a patient who recently stopped drinking heavily.
2. Detoxification of cannabinoids, stimulants, or hallucinogens alone does not require inpatient level of medical intervention; however, multiple substance abuse with components of alcohol, opiates, or sedatives may be considered for inpatient admission.
3. Inpatient acute care services for the treatment of chronic, medically uncomplicated drug dependence or alcoholism are not covered benefits.
4. Voluntary inpatient detoxification where the primary reason for admission is substance abuse detoxification is a carve out benefit to Medi-Cal fee-for-service.

ADDITIONAL INFORMATION

None

CLINICAL/REGULATORY RESOURCE

1. **Voluntary Inpatient Detoxification (DHCS APL 18-001, released January 11, 2018):**
   The purpose of the All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification regarding voluntary inpatient detoxification (VID) services, which are a Medi-Cal covered benefit that is available to MCP members through the Medi-Cal fee-for-service (FFS) program. Members who meet medical necessity criteria may receive VID services in a general acute care hospital. To receive VID services under the FFS benefit, inpatient detoxification must be the primary reason for the member's voluntary inpatient admission.

   To receive these services, MCPs must refer members to a VID provider in a general acute care hospital. The VID provider facility must not be a Chemical Dependency Treatment Facility or Institution for Mental Disease. The VID provider must submit a Treatment Authorization Request (TAR) to local Medi-Cal field offices for approval. MCPs must provide care coordination with the VID provider as needed. Additional documents submitted

with the TAR should verify that the beneficiary's condition satisfies admission criteria and demonstrates the medical necessity for the inpatient stay.

2. **Manual of Criteria for Medi-Cal Authorization:**
   Per section 5.0, Criteria for Hospital Services (Inpatient), treatment for alcoholism per se is not a covered benefit under the Medi-Cal program. Documented medical disorders, whether related or unrelated to alcoholism, may be justification for admission to a hospital.

   Per section 5.0, Criteria for Hospital Services (Inpatient), treatment for drug dependence per se is not a covered benefit under the Medi-Cal program.

   Per section 5.0, Criteria for Hospital Services (Inpatient), detoxification from narcotics is only covered on an outpatient basis. Inpatient medical treatment for drug overdose and life-threatening withdrawal from barbiturates, sedatives, or hypnotics may be covered.

3. **Medical Review Criteria Guidelines for Managing Care (Apollo):**
   Per the Addenda section for Critical Care, critical care services require personal management by the physician. Services are life and organ supporting interventions that require personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate, these intervention on an urgent basis, would likely result in sudden and clinically significant or life-threatening deterioration on the patient's condition.

   In order to reliably and consistently determine the medical necessity of critical care services, both of the following medical review criteria must be met:
   A. Clinical Condition Criterion: There is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition, which requires the highest level of physician preparedness to intervene urgently.
   B. Treatment Criterion: Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration in the patient's condition.

Critical care services include but are not limited to, the treatment or prevention or further deterioration of central nervous system failure, circulatory failure, shock-like conditions, renal, hepatic, metabolic, or respiratory failure, postoperative complications, or overwhelming infection.

DEFINITION OF TERMS

Current Procedural Terminology (CPT):

CPT codes 99291 and 99292 define a critical illness as follows:
Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ system such that there is a high probability of imminent or life-threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

REFERENCES

1. All Plan Letter 14-005 – State of California-Health and Human Services Agency, Department of Health Care Services, March 11, 2014. Available at http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/gm201402.asp#a4
2. All Plan Letter 14-004 – State of California Health and Human Services Agency Department of Health Care Services, February 10, 2014. Available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-004.pdf
3. All Plan Letter 18-001 – State of California Health and Human Services Agency Department of Health Care Services, January 11, 2018. Available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-001.pdf
4. Apollo Medical Review Guidelines for Managing Care – ~~(~~17th Edition, 5th Online Edition, 2018~~)~~. MDC 26-250 Addenda: Critical/Intensive Care Services/Long Term Acute Care
5. Manual of Criteria for Medi-Cal Authorization, Chapter 5.0, Criteria for Hospital Services (Inpatient) and Chapter 5.2 Psychiatric Diagnosis, pgs 5.2.1, 5.2.12-12-14. (2004)
6. Current Procedural Terminology (CPT) 2017 Professional Edition

This guideline was developed using the following resources: Apollo Medical Review Criteria Guidelines for Managing Care (2018), Manual of Criteria for Medi-Cal Authorization (2004), and Current Procedural Terminology (CPT) 2017 Professional Edition.

DISCLAIMER

IEHP Clinical Authorization Guidelines (CAG) are developed to assist in administering plan benefits, they do not constitute a description of plan benefits. The Clinical Authorization Guidelines (CAG) express IEHP's determination of whether certain services or supplies are medically necessary, experimental and investigational, or cosmetic. IEHP has reached these conclusions based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). IEHP makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in the Clinical Authorization Guidelines (CAG). IEHP expressly and solely reserves the right to revise the Clinical Authorization Guidelines (CAG), as clinical information changes.