



TOBY DOUGLAS  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

**DATE:** MARCH 11, 2014

ALL PLAN LETTER 14-005

**TO:** ALL MEDI-CAL MANAGED CARE HEALTH PLANS

**SUBJECT:** NEW BENEFIT—VOLUNTARY INPATIENT DETOX

**PURPOSE:**

The purpose of this All Plan Letter (APL) is to notify all Medi-Cal managed care health plans (MCPs) of a new fee-for-service (FFS) Medi-Cal benefit that is available to Medi-Cal beneficiaries. Beneficiaries who meet medical necessity criteria may receive voluntary inpatient detoxification (VID) services in a general acute care hospital, as defined in this APL and in Medi-Cal Provider Bulletin 476.<sup>1</sup>

**BACKGROUND:**

The State established VID services as a FFS Medi-Cal benefit under Section 29 of Senate Bill 1 of the First Extraordinary Session of 2013 (Hernandez & Steinberg, Chapter 4, Statutes of 2013) and consistent with Section 1302(b) of the Affordable Care Act of 2010.

**POLICY:**

Medical criteria for inpatient admission for voluntary inpatient detoxification 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:
  - Hallucinations;
  - Disorientation;
  - Tachycardia;
  - Hypertension;
  - Fever;
  - Agitation; or
  - Diaphoresis.
  
2. Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) form score greater than 15.

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<sup>1</sup> Available at: <http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/gm201402.asp#a4>.

3. Alcohol/sedative withdrawal with CIWA score greater than 8 *and* one or more of the following high risk factors:
  - o Multiple substance abuse;
  - o History of delirium tremens;
  - o Unable to receive the necessary medical assessment, monitoring, and treatment in a setting with a lower level of care;
  - o Medical co-morbidities that make detoxification in an outpatient setting unsafe;
  - o History of failed outpatient treatment;
  - o Psychiatric co-morbidities;
  - o Pregnancy; or
  - o 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:
  - o Persistent vomiting and diarrhea from opioid withdrawal; and
  - o Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care.

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.

To receive these services, the MCP must refer its member 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 field offices for approval. The MCP must provide care coordination with the VID provider as needed. Additional documents submitted with the TAR should verify that the beneficiary's condition satisfies admissions criteria and demonstrates the medical necessity for the inpatient stay.

DHCS formulated these coverage criteria based on the references attached to the end of this APL. If you have any questions regarding this APL, please contact your MMCD contract manager.

Sincerely,

*Original Signed by Margaret Tatar*

Margaret Tatar  
Assistant Deputy Director  
Health Care Delivery Systems

## Attachment 1: Coverage Criteria

DHCS formulated the coverage criteria for voluntary inpatient detoxification services based on the following references:

1. Hartwell K, MD; Brady K MD, PhD; et al. "Clinical management of substance dependence across the continuum of care." (Internet) UpToDate: <http://www.uptodate.com/home>. Accessed September 27, 2013.
2. Volpicelli JR MD, PhD; Teitelbaum SA, MD; et al. "Ambulatory alcohol detoxification." (Internet) UpToDate: <http://www.uptodate.com/home>. Accessed September 27, 2013.
3. Foy A; March S; Drinkwater V. "Use of an objective clinical scale in the assessment and management of alcohol withdrawal in a large general hospital." *Alcoholism: Clinical and Experimental Research*. 1988. 12(3): 360–364.
4. Monte R; Rabunal R; Casariego E; et al. "Risk factors for delirium tremens in patients with alcohol withdrawal syndrome in a hospital setting." *European Journal of Internal Medicine* 2009; 20(7): 690–694.
5. McKeon A; Frye MA; Delanty N. "The alcohol withdrawal syndrome." *Journal of Neurology, Neurosurgery, and Psychiatry* 2008; 79(8): 854–862.
6. Haber PS; Demirkol A; Lange K; Murnion B. "Management of injecting drug users admitted to hospital." *Lancet* 2009; 374(9697): 1284–1293.
7. Weaver MF, MD; Hopper JA, MD. "Medically supervised opioid withdrawal during treatment for addiction." (Internet) UpToDate: <http://www.uptodate.com/home>. Accessed September 27, 2013.
8. Kelber HD, MD; Weiss RD, MD; Anton Jr. RA, MD; et al. "Practice guideline for the treatment of patients with substance use disorders. 2nd edition." (Internet) American Psychiatric Association 2007: <http://psychiatryonline.org/guidelines.aspx>. Accessed September 27, 2013.
9. Sullivan JT; Sykora K; Schneiderman J; Naranjo, CA; Sellers EM. "Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar)." *British Journal of Addiction* 1989; 84: 1353–1357.