

**LAKESHORE REGIONAL ENTITY**  
**Substance Use Disorder Residential Withdrawal Management**

*This service must be provided consistent with requirements outlined in the MDHHS Medicaid Provider Manual as updated. The manual is available at:*

<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>

**1. Definition or Description of Service**

- a. Definition of Withdrawal Management (formerly known as Detoxification) – SAMHSA’s TIP #45, *Detoxification and Substance Abuse Treatment: Treatment Improvement Protocols* defines detoxification as “a set of interventions aimed at managing acute intoxication and withdrawal.” It denotes a clearing of toxins from the body of the individual who is acutely intoxicated and/or dependent on substances of abuse. The ASAM Criteria 3.0 states “when a person’s substance use disorder has progressed to the point that physical dependence has developed, withdrawal management becomes the first (but not the sole) priority in treatment planning.” ASAM further states that “current medication protocols now allow all but the most severe withdrawal syndromes to be managed effectively on an ambulatory basis”. ASAM identifies the following levels of care for withdrawal management:
  - Level 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring
  - Level 2-WM: Ambulatory Withdrawal Management with Extended On-Site Monitoring
  - Level 3.2-WM: Clinically Managed Residential Withdrawal Management
  - Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management
  - Level 4-WM: Medically Managed Intensive Inpatient Withdrawal Management
- b. Michigan’s licensing rules for substance abuse treatment programs presently require withdrawal management (detox) to be offered within a residential treatment program facility. Accordingly, the LRE offers support for withdrawal management at ASAM Levels 3.2-WM and L3.7-WM.
  - Level 3.2-WM: Clinically Managed Residential Withdrawal Management – Services address moderate withdrawal with needs for 24-hour support to complete withdrawal management protocol and to increase the likelihood of the patient continuing treatment or recovery.
  - Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management – Services address severe withdrawal with needs for 24-hour nursing care and physician visits (as necessary) to complete withdrawal management protocol. The patient would be one unlikely to complete withdrawal management without medical care and nursing monitoring.

**2. Practice Principles**

- a. Withdrawal management alone is not sufficient treatment for substance dependence, but it is one part (typically a first step) in a sequence of care for a person with a substance-use disorder who faces the challenge of physiological withdrawal.
- b. Individuals seeking withdrawal management services have diverse cultural and ethnic backgrounds, as well as unique health needs and life situations. Providers should take into account specific cultural and or unique health needs when evaluating the proper level of care. Recovery planning should be done in conjunction with the individual and his or her family, friends or other significant people.
- c. Staff working with an individual entering withdrawal management has a basic responsibility to assist the individual with recognizing that recovery is possible. Staff members must aid individuals with identifying potential obstacles that could prevent them from moving forward with stages of change and making progress in their recovery.

- d. Motivational interviewing has been shown to be highly effective in assisting an individual to begin to make changes. Therefore, the LRE strongly recommends that each staff member assisting an individual in the recovery process has at least a basic understanding of motivational interviewing.
- e. Facilities that provide level 3.7-WM care should have the capacity to seamlessly transition patients to level 3.2-WM as their overall medical/clinical status warrants.

### 3. Credentialing Requirements

- a. The program must hold a current license for residential detox services from Michigan's office of [Licensing and Regulatory Affairs](#).
- b. Professional staff must have a Master's degree in an approved field of behavioral health and meet the qualifications of a "Substance Abuse Treatment Practitioner" (SATS) per the [Michigan PIHP/CMHSP Provider Qualifications Chart](#).
- c. Master's level professional staff must also be credentialed by the [Michigan Certification Board for Addiction Professionals](#) as a CAADC, CADC, CCJP, or CCDP-D (or have a development plan for one of these credentials).
- d. Staff who provide didactic (teaching) interventions within an Intensive Outpatient Program must have a Bachelor's degree and [Michigan Certification Board for Addiction Professionals](#) credential (or have a development plan).
- e. Staff must be supervised by a Master's prepared Clinical Supervisor with a MCBAP certified clinical supervisor certification (or development plan). Please refer to the [Michigan PIHP/CMHSP Provider Qualifications Chart](#) and [MCBAP](#) for a detailed listing of certification options and requirements, including student intern requirements.
- f. Acupuncture may be performed by the following individuals: a) Medical Doctor, b) Doctor of Osteopathy, and c) Registered Acupuncturist. An individual who holds a Certificate of Training in Detoxification Acupuncture as an Acupuncture Detoxification Specialist (ADS) issued by the National Acupuncture Detoxification Association (NADA) and is under the supervision of a person licensed to practice medicine in the state may use the NADA protocol for substance use disorder treatment.
- g. Recovery Supports – The individual completed Recovery Coach Training in compliance with DHHS requirements and is supervised by a Master's prepared clinical supervisor.
- h. As these standards are now being uniformly applied across the LRE region, providers with specific challenges in meeting these requirements with legacy staff should contact their contracting entity to discuss options for compliance.

### 4. Service Requirements

- a. [Medicaid/Healthy Michigan Service Requirements](#) – Services provided to MAT program clients must comply with all current provisions of Michigan's Medicaid Manual, which incorporates the Healthy Michigan Plan and is available at <http://www.michigan.gov/mdhhs/0,5885,7-339--87572--,00.html>.
- b. [Organization](#) – This service is an organized service delivered by medical and nursing professionals, who provide 24-hour medically supervised evaluation and withdrawal management.
- c. [Withdrawal Symptoms](#) are evaluated through the use of either the Clinical Institute Withdrawal Assessment (CIWA) or the Clinical Institute Narcotic Assessment (CINA), or another assessment tool. Services are delivered under a defined set of physician approved policies and physician monitored procedures or clinical protocols. This level provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services.

- d. Daily Clinical Services to assess and address the needs of each individual. Such clinical services may include appropriate medical services, individual and group therapies, and withdrawal support.
- e. A Range of Cognitive, Behavioral, Medical, Mental Health, and Other Therapies are administered to the individual on an individual or group basis designed to enhance the individual's understanding of addiction, the completion of the withdrawal process, and referral to an appropriate level of care for continuation of treatment.
- f. Medication Withdrawal Management – A client may receive methadone for the purposes of withdrawal management or maintenance, defined as the dispensing of drugs in decreasing doses to an individual in order to alleviate adverse physiological or psychological effects incident to withdrawal from the continuous or sustained use of a narcotic drug. It is also used as a method of bringing the individual to a narcotic-free state within a specified period. There are two types of medication withdrawal management: 1) short-term withdrawal management is for less than thirty (30) days; and 2) long-term withdrawal management is for between 30 and 180 days.
- g. Provider Expectations – Providers are expected to:
  - i. General
    - 1. Provide co-occurring capable services in a welcoming environment.
    - 2. The program must have daily therapeutic programming which is individualized to meet the unique needs of the individual served. Treatment planning and treatment is individualized and individual specific.
    - 3. Have the ability to admit pregnant women who are eligible for the program within 24 hours.
  - ii. Clinical
    - 1. Evaluation of an individual for withdrawal management – Providers evaluating an individual's need for withdrawal management must recognize the signs of withdrawal. Providers must consider the severity of each symptom present in determining the need for withdrawal management services.
    - 2. SAMHSA, in TIP #45, Detoxification and Substance Use Treatment lists the following signs of withdrawal:
      - a. Restlessness, irritability, anxiety, agitation
      - b. Anorexia (lack of appetite), nausea, vomiting
      - c. Tremors (shakiness), elevated heart rate
      - d. Insomnia, intense dreaming, nightmares
      - e. Poor concentration, impaired memory and judgment
      - f. Increased sensitivity to sound, light, and tactile sensations
      - g. Hallucinations (auditory, visual, or tactile)
      - h. Delusions, usually of paranoid or persecutory varieties
      - i. Grand mal seizures
  - iii. Provide services and/or interventions that are stage-matched with ongoing evaluation to meet changing needs and abilities, including referrals to alternative services as needed.
  - iv. Providers are expected to treat individuals who may also be enrolled in a medication assisted treatment program (Methadone/Suboxone). Provider should coordinate the individual's care with the Medication Assisted Treatment program.
  - v. Provide integrated screening, data collection/reporting, assessment, and treatment planning.
  - vi. Coordinate discharge planning and aftercare services to ongoing treatment services (through clinical staff, case managers, or recovery coaches as applicable). The patient should be prepared for their referral to ongoing services and engagement should be

facilitated by the program or clinically responsible individuals involved with the patient outside of the program. The aim must be to responsibly link the patient to services that are needed to support the progress made during the episode of withdrawal management and provide those services that will address the patient's need for the development of recovery skills and stable recovery.

- vii. Medical
  - 1. Medical care should be coordinated through the individual's primary care physician.
  - 2. Services must include evaluations for psychotropic medication (by qualified medical professionals) when needs are identified. Provider will need to assume responsibility to pay for psychotropic medications when need is identified. Provider will remain responsible for psychotropic medication needs for 30 days after discharge unless a subsequent services provider assumes this responsibility earlier.
- viii. Regulatory
  - 1. Agencies providing Withdrawal Management services for Medicaid beneficiaries must adhere to all applicable regulations and requirements set forth in the Medicaid Provider Manual.
  - 2. The case note for all group services will record the number of individuals in the group.
- h. Communicable Disease (Screening and Testing):
  - i. All individuals must be screened at assessment for risk of TB, STD, HIV, and Hepatitis in a manner that is consistent with the MDHHS Best Practice.
  - ii. If the screen identifies high-risk behavior, the individual must be referred for testing.
  - iii. Referral for testing is required for the following populations:
    - 1. Hepatitis C for all individuals with history of IDU.
    - 2. STD and HIV testing for all pregnant women.
  - iv. Mandatory TB testing for all individuals entering residential treatment within 48 hours of admission.
  - v. Referral agreements with Communicable Disease testing sites.
  - vi. Method for ensuring that the agency to which the individual has been referred has the capacity to accept the referral.
  - vii. Protocol for linking infected individuals with appropriate treatment/support resources.
  - viii. Protocol for recording the screening, referral, and linking activities in the individual's file.
  - ix. Completion of the Communicable Disease reporting requirements as specified by the Office of Recovery Oriented Systems of Care (OROSC).
- i. Health Education and Risk Reduction:
  - i. All individuals who are identified as having high risk behaviors must receive Health Education and Risk Reduction services delivered by a qualified provider.
  - ii. Health Education and Risk Reduction services must be documented in the individual's file.
  - iii. Staff Capability:
    - 1. A Training Plan to provide program staff with Level I Training as described in the APG, delivered by a qualified provider.
    - 2. A Training Plan to provide treatment staff with Level II Training as described in the APG, delivered by a qualified provider.
    - 3. Documented evidence of the implementation of the Training Plan.
- j. Fetal Alcohol Spectrum Disorder (FASD):

- i. FASD prevention information must be provided to men and women in all substance use disorder treatment programs.
- ii. For any treatment program that serves individuals with children, it is required that the program complete the FASD Pre-Screen for children they interact with during the treatment episode. In the event a child has a positive pre-screen, a referral must be made to a Fetal Alcohol Diagnostic Clinic.
- k. Michigan Mission-Based Performance Indicator System Access Requirements:
  - i. Ninety-five percent (95%) of persons requesting a screening for eligibility must be seen within 14 days from the request for service.
  - ii. Ninety-five percent (95%) of persons determined to be eligible for Network180 ongoing services must be seen within 14 days of the date of determination.
  - iii. Ninety-five percent (95%) of persons discharged from withdrawal management services must be seen within 7 days for follow-up.
  - iv. Ninety-five percent (95%) of persons discharged from psychiatric inpatient services must be seen within 7 days for follow-up.
- l. Co-Occurring Disorders – Individuals with co-occurring disorders that are admitted to a withdrawal management program must be screened for prescribed addictive medications. For individuals that are prescribed addictive psychotropic medications, the withdrawal management program must consult with the prescribing physician to assess if the individual can be switched to non-addictive medications.
- m. Service Coordination – The following coordination efforts are required of providers delivering withdrawal management services. Please note that for residential withdrawal management services the short-term residential following withdrawal management is considered to be a part of the same level of care. Therefore, the following expectations would be expected by discharge from short-term residential.
- n. Treatment services should be holistic in nature and occur within a recovery oriented system of care.
- o. Providers are encouraged to seek appropriate interventions from alternative therapies, such as; occupational (sensory integration) therapy, physical therapy (recreational therapy), and acupuncture.
- p. Withdrawal management providers must develop a treatment/recovery plan that addresses all assessed needs. The treatment/recovery plan should identify agencies in the individual's home county that can provide services following discharge. If a withdrawal management provider is unsure of available resources in an area they should contact the CMHSP Access Center.
- q. A client may not be admitted to withdrawal management services without signing a release of information form for all personal care physicians, dentists, and mental health professionals serving the client. Providers must engage in care coordination with an individual's personal care physician, dentist, mental health professional and CMHSP Access Center staff as appropriate.
- r. Withdrawal management providers must work to promote continuity of treatment at the level of care. Therefore, it is expected that they:
  - i. Perform assessment of urgency for treatment during transitional planning at the next level of care.
  - ii. Prioritize treatment goals/outcomes during transitional planning for the next level of care.
  - iii. Provide information to the client on Substance Use Disorder Treatment, including, information on what to expect at the first appointment at the next level of care
  - iv. Engage the support of family members as appropriate.
  - v. Introduce the client to the counselor at the next provider who will deliver rehabilitation services (this can be done via telephone and/or face to face).

- vi. Ensure the individual knows the date, time, and place of their next level of care appointment.
- vii. Provide contacts for support group meetings in the individual’s home area.
- s. The withdrawal management provider shall submit the developed treatment/recovery plan and discharge summary to the level provider and CMHSP.

**5. Training Requirements**

- a. See Attachment I: Training Requirements for specific training requirements and frequency of trainings.
- b. Provider will ensure and document that each staff is trained on the individual’s plan of services prior to delivery of service.

**6. Eligibility Criteria**

- a. Admission – An individual must meet medical necessity for withdrawal management services based on current ASAM criteria for withdrawal management (Level 3.2-WM or Level 3.7-WM). The individual must meet all three of the criteria listed below:

<b>1</b>	The client is experiencing signs and symptoms of severe withdrawal or there is evidence based on history of substance intake, age, gender, previous withdrawal, physical conditions, and/or emotional/behavioral/cognitive condition.
<b>2</b>	The individual is experiencing severe withdrawal that cannot be handled at a lower level of care.
<b>3</b>	<p>The individual has a SPMI or cognitive disorder that would complicate treatment and thus required 24-hour monitoring.</p> <p style="text-align: center;">OR</p> <p>The individual has a long history of abusing alcohol and/or benzodiazepines.</p> <p style="text-align: center;">OR</p> <p>Patient is presently suffering from a significant medical disorder related to substance use that would complicate treatment and require 24-hour monitoring.</p>

- b. Criteria:
  - i. Withdrawal management services are intended to assist individuals in the process of withdrawal from substance(s) in preparation for continued substance use or co-occurring disorder treatment.
  - ii. Individuals served must meet ASAM (American Society of Addiction Medicine) criteria for this service.
  - iii. Individuals with a co-occurring Axis I mental health and substance use disorder are eligible and welcomed into this service.
  - iv. The individual needs to be in active withdrawal as evidenced by a defined COWS, CINA or CIWA score, or other assessment tool.
- c. In instances where the presenting alcohol/other drug history is inadequate to substantiate such a diagnosis, the material submitted by other health care professionals and programs, collateral’s (such as family members, legal guardians, et. al.,) indicates a high degree of probability of such a diagnosis, based on further evaluation.
- d. Discharge – An individual may be discharged from withdrawal management services if they meet one of the three of the criteria listed below:

<b>1</b>	The individual is not engaging in treatment services, is disruptive, and non-compliant with residence rules and/or policies.
<b>2</b>	The individual chooses to leave treatment early against the advice of clinical staff.
<b>3</b>	<p>Completion of current prescribed treatment.</p> <p style="text-align: center;">AND</p> <p>Individual is off all medications that were used for withdrawal management EXCEPT if the plan is for the patient to be maintained on buprenorphine or methadone with appropriate referral, or; the patient has been stabilized on a sedative, with appropriate referral, to an outpatient detox service or another level of care in which the medication can be slowly tapered.</p> <p style="text-align: center;">AND</p> <p>The individual's vital signs have normalized and/or medical condition is stabilized to the degree that they can be treated in an outpatient setting.</p> <p style="text-align: center;">AND</p> <p>Withdrawal screening tool (CIWA, COWS, other assessment tool, etc....) is now in normal range.</p> <p style="text-align: center;">AND</p> <p>Transfer coordination with the next level of care provider has been completed.</p> <p style="text-align: center;">AND</p> <p>The individual is linked to social and/or environmental supports required for successful recovery (in their local area).</p>

## 7. Access Requirements

- a. Priority Populations – Provider will prioritize services for the following populations (below). Admission time line standards will be met as stated in the contract. For pregnant women, if Provider cannot provide services within 24 hours, the individual will be referred back to the CMHSP and then referred to an alternative service provider.
  - i. Pregnant Women-Injecting Drug Users – if the opiate use is significant, please refer to MAT services. If opiate use is not significant, detox can be commenced.
  - ii. Pregnant Women
  - iii. Injecting Drug Users who have injected drugs in the past 30 days
  - iv. Parents whose children have been removed from the home under the Child Protection Laws of this State or are in danger of being removed from the home because of the parents' substance abuse
  - v. All others
- b. Authorizations for withdrawal management services admissions can only occur through the CMHSP.
- c. Individuals with Medicare insurance coverage will be referred to a Medicare Provider.
- d. Authorizations through the CMHSP shall occur in the same manner as admission to other services. All authorizations for this level of care must meet the current ASAM criteria for withdrawal management services.
- e. In order to ensure that withdrawal management services are prioritized for persons with the greatest need and to ensure that withdrawal management services continue to be a gateway into substance use disorder treatment, CMHSP has developed with providers the additional withdrawal management screening guidelines.
  - i. "Emergent" referrals are admissions in which a diversion from psychiatric inpatient is made because of a primary or co-occurring substance use disorder needs

- immediate treatment.
- ii. Can be used for detox services or short term residential (IS) services.
- iii. Include admissions that occur between the hours of 5:00 pm and 8:00 am on weekdays and any time on weekends and holidays. For the purposes of this agreement, holidays include New Year's Day, Martin Luther King Day, President's Day, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving Day, Christmas Day, and the day after Christmas Day.
- iv. All emergent admissions must have CMHSP approval, and the CMHSP manager's name must be noted.
- f. Discharge
  - i. Provider must complete the substance use disorder discharge treatment form in the authorization system within 2 business days.
  - ii. All discharge summaries must be mailed or faxed to CMHSP within 10 business days of the individual's discharge.

## 8. Authorization Procedures

- a. Individuals will generally be authorized for:
  - i. 3 days of care for alcohol withdrawal,
  - ii. 2 days of care for opiate withdrawal when the plan includes transfer to a Medication Assisted Treatment program, or
  - iii. 5 days of care for benzodiazepine withdrawal or opiate withdrawal when the plan does not include transfer to a Medication Assisted Treatment program.
- b. Continued stay authorizations will be generally for 1 day at a time based on a utilization review and the presence of continuing medical symptoms.
- c. If the request for additional days of care is denied, the provider can request reconsideration through the UM Department Manager.
- d. All services authorized will be based on ASAM criteria, medical necessity, and the validation of eligibility.
- e. All authorizations will reflect the required timelines and the requirements established by MDHHS.

## 9. Relevant Forms

- a. Michigan's Medicaid Manual, which incorporates the Healthy Michigan Plan (<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>)
- b. Michigan PIHP/CMHSP Provider Qualifications per Medicaid Services & HCPCS/CPT Codes ([https://www.michigan.gov/documents/mdch/PIHP-MHSP\\_Provider\\_Qualifications\\_219874\\_7.pdf](https://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf))