



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Outpatient detoxification and follow-up care protocols

For treating substance use disorders

For Blue Cross' PPO (commercial), Medicare Plus BlueSM PPO, BCN HMOSM (commercial) and BCN AdvantageSM members

September 2020

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Blue Cross Blue Shield of Michigan and Blue Care Network support using outpatient protocols for detoxification and delivering outpatient services via telemedicine when medically appropriate.

This document provides information that will help you determine the appropriate detoxification method and follow-up care for a patient being treated for substance use disorders.

The protocols described in this document are:

- For outpatient detoxification and continued treatment for members with mild and mild-to-moderate substance use disorders

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- For next steps with members who have severe substance use disorders and high-risk detoxification needs
- Designed to support outpatient detoxification and follow-up treatment by maximizing the use of available outpatient resources and telemedicine services in line with evidence-based practices
- Especially useful with members for whom the morbidity and mortality risks are low when compared to the risks of exposing them to other patients with infectious diseases or toxic conditions through hospitalization

While Blue Cross and BCN support the use of these protocols, it's the treating physician who must decide which treatment protocol is medically appropriate for an individual patient at any given time in the course of his or her disease.

We encourage providers to address a range of patient needs by offering a variety of treatment protocols using in-person and telemedicine delivery mechanisms to the extent they are able.

Triage and assessment

Here are the initial steps in determining which detoxification treatment option is most appropriate for a patient:

1. **Triage the patient.** Each patient needs to be screened, via telemedicine (audiovisual or telephone-only visit).
2. **Assess the patient.** The provider must determine the severity of the patient's substance use disorder and the risk of morbidity or mortality associated with the patient's level of detoxification.

Note: There are several scales used in emergency rooms but, typically, the assessment is based on the clinical evaluation and experience of the treatment team.

Determining the appropriate type of detoxification

When determining which treatment options are most appropriate for a patient, you need to consider the patient's level of morbidity and weigh the risks against the benefits.

Patient's level of morbidity

Consider using outpatient detoxification for patients with mild (less than 10% risk of morbidity) to moderate (less than 20% risk of morbidity) substance use disorders. For patients with severe substance use disorders, outpatient detoxification carries a higher risk of morbidity and mortality. A decision to use outpatient detoxification needs to be considered in light of the risks outlined below.

Risks vs. benefits

The critical determination is whether the member is at greater risk of dying or becoming severely ill from:

- Outpatient detoxification, if inpatient detoxification is less risky or
- Hospitalization, if the patient is exposed to other patients who are ill.

The risk/benefit analysis is a decision that must be made by the treating physicians.

Examples of risk/benefit analyses:

- **Example 1.** A 25-year-old male who abuses alcohol with no prior history of seizures and no medical issues related to withdrawing from Xanax[®] and alcohol. This patient's risk of seizure is about 1%, especially if given medications such as a phenobarbital IV loading infusion and daily check-ins with oral medication at home. Check-ins by visiting nurses might be done in addition to the telemedicine (audiovisual or telephone-only) check-ins. The risk of a negative outcome with outpatient detoxification is relatively low, but hospitalization carries a more finite risk of morbidity and mortality. The risk/benefit analysis favors detoxification at home with a phenobarbital loading and oral medications.
- **Example 2.** A 65-year-old white male who ingests 1 gallon of liquor daily and who has diabetes, hypertension, liver disease and frequent pancreatitis. This patient's risk of morbidity and mortality is substantially higher, but the risk of mortality is especially high. The risk/benefit analysis favors a slightly longer inpatient detoxification of up to 7 days, instead of 3 to 5 inpatient detoxification days, plus an inpatient residential stay of 7 to 10 days. The decision about the length of stay would be based on current medical necessity criteria and may benefit from a discussion between the attending physician and the medical director of the plan. The complete treatment plan must be considered when deciding whether a longer length of stay is warranted as opposed to the patient going directly home rather than spending additional time on an inpatient unit.

When outpatient detoxification may be appropriate

Many well-documented outpatient detoxification protocols can address an individual's needs and be carried out safely. Here are some things to consider:

- **Services needed.** All the services that are needed, such as assessment, medical examination, vitals and monitoring protocols, can be reimbursed through professional fees and can be delivered via telemedicine, if appropriate. Therapies such as individual psychotherapy, group therapy and family therapy are covered services and can also be helpful to the patient. Frequent check-ins each day until the member is stable are a significant component of the process and are also covered by Blue Cross and BCN through existing medical and billing policies.
- **Algorithms.** Specific algorithms developed for other settings may be applicable to the needs of an outpatient in an ambulatory care setting. These include:
 - [Yale protocol](#)** for emergency room evaluation and the induction of patients on medication-assisted treatment, or MAT
 - [American Society of Addiction Medicine](#),** or ASAM, information, which could be applied to specific patients for whom outpatient detoxification may be an appropriate option
 - [Washington Manual of Medical Therapeutics](#),** which can assist with the selection of treatment protocols
 - [UptoDate](#),** which can assist with the selection of treatment protocols
 - University of Michigan Collaborative, which offers a real-time or asynchronous resource for expert consultation in difficult cases.

Note: Providers who treat patients with substance use disorders and who want more information about MAT can email moc-administration@umich.edu or call 734-763-9500.

- [New Directions](#)®,** which offers a specific opioid hotline to assist with the management of difficult-to-treat opioid treatment scenarios

When inpatient detoxification may be appropriate

There are times when inpatient detoxification protocols are more appropriate. Here are some things to consider:

- Inpatient care is warranted if the treating physicians determine that an admission for inpatient detoxification meets the pertinent InterQual[®] and New Directions medical necessity criteria and the risk of complications from the substance use withdrawal is higher than the risk of morbidity and mortality associated with hospitalization.
- The inpatient period needs to be as short as possible to minimize the risks inherent in inpatient settings, but it needs to be long enough to stabilize the patient so he or she can transition home and into outpatient care.

Coordination of care to meet referral and authorization requirements for detoxification

All the behavioral health and medical providers treating a patient must coordinate their care with the primary care physician to ensure that all required referrals and authorizations are in place for detoxification services. Here are the requirements:

- **For outpatient detoxification:**
 - Referrals from the primary care physician are needed for BCN HMO members in the East or Southeast region in Michigan

Note: The primary care physician referral can be obtained by the member. It can also be obtained by the treatment team once a release of information has been completed for this purpose by the patient.
 - No primary care physician referrals are needed for:
 - BCN HMO members in the Mid, West, or Upper Peninsula region in Michigan
 - BCN Advantage members in any region
 - All Blue Cross' PPO and Medicare Plus Blue members
- **For inpatient detoxification,** authorization by the plan or by a vendor contracted with the plan is required, for all Blue Cross and BCN members.

Post-detoxification follow-up care via telemedicine

After detoxification, the patient will need continuing treatment.

The specific treatment and supportive treatments listed below represent the components of a vigorous treatment plan that can be delivered via telemedicine and that allow the patient to avoid residential or other in-person rehabilitation care with its higher risks of morbidity and mortality:

- Continuing close follow-up care with the use of:
 - Partial hospital program, or PHP, services
 - Intensive outpatient program, or IOP, services
 - Routine outpatient services
 - A combination of these
- Family therapy
- Continuing group therapies along with any community resources that may be available via telemedicine
- Referral to community resources such as Alcoholics Anonymous, Narcotics Anonymous, AI-Anon and Nar-Anon groups supplemented by provider meetings and behavioral health resources delivered via telemedicine

For additional information on telemedicine services for behavioral health, refer to the document [Telehealth for behavioral health providers](#).

PHP or IOP services via telemedicine

Because of the importance of social distancing during times of inordinate infectious disease risk or for patients in rural settings, the use of standard PHP or IOP services delivered via telemedicine would be a significant part of the outpatient initial treatment.

Note: Effective for dates of service on or after April 16, 2020, and until further notice, Blue Cross and BCN reimburse PHP and IOP services delivered via telemedicine, for members who have these benefits.

Here are some things to consider:

- The enhanced social contact afforded through IOP services (or PHP services, if the member has that benefit) and the possibility of mixing virtual and face-to-face services results in a flexibility of service delivery that can be extremely helpful to patients.
- IOP services would likely last for at least 12 sessions, although the length of time depends on the needs of the individual patient. Additional sessions can be authorized if medical necessity criteria are met.
- Current authorization requirements apply, for both the initial admission to PHP or IOP and for continuing stays. See below for a summary showing which treatment

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protocols for members with substance use disorders require authorization by the plan or by a vendor contracted with the plan:

Line of business	Is authorization required?	
	PHP	IOP
Blue Cross' PPO	Yes	No
Medicare Plus Blue	Yes	Yes
BCN HMO	Yes	Yes
BCN Advantage	Yes	Yes

These requirements apply whether the services are delivered to members participating in person or via telemedicine.

Providers should use web-DENIS to check each member's benefits related to the treatment of substance use and mental health disorders.

Routine outpatient services via telemedicine

The longer patients remain engaged, the more likely it is that they'll stay well. Patients can continue their family and individual therapy, medically facilitated treatment group therapy and medication reviews using existing telemedicine resources.

No referral or authorization is required for routine outpatient services, for members who have these benefits. This applies whether the services are delivered to members participating in person or via telemedicine.

Providers should use web-DENIS to check each member's benefits related to the treatment of substance use and mental health disorders.

Essential elements of any care plan

Care plans for all patients should include the following elements.

Family assessment

Families and other support persons are critical to the long-term wellness of the identified patient. Here's what we know:

- Roughly 40% of patients' families or other support persons have significant substance use disorder issues themselves. Addressing their needs in terms of case-finding and identification helps the patient and everyone else.

- Most of the time, immediate family members have the same insurance benefit and can use those benefits for services similar to those the identified patient is receiving.

Substance use disorder advance directive (contingency management)

Contingency management is a crucial component of all care plans, as patients will be tempted to return to substance use. When they are thinking clearly, patients need to consider what they would do to avoid a return to old habits.

Providers should consider identifying all patients' wishes if they were readmitted, including where they want to go and what interventions they would accept. This may help divert early readmissions and get patients back on track to wellness.

Medication-assisted treatment and medically facilitated treatment

Contingency management is a crucial component of all patients' care as they will be tempted to return to substance use. Critical components of this treatment are MAT and medically facilitated treatment. Here's why:

- MAT helps because the patient doesn't have the positive social pressures of the inpatient residential level of care to rely on for support.
- MAT can help with the additional stressors and temptations in the home environment with which the patient will need assistance.
- MAT can decrease or eliminate risks of overdose or return to substance use patterns in an ineffective attempt to cope.
- Medically facilitated treatment offers anti-craving medications and medications that have demonstrated a neutral reward for use or that can shorten the acclimation/healing process from the negative effects of the drug used support the patient recovering without the structure of traditional face-to-face treatments.

These interventions are some of the components of the care and intervention needed. They are important for addressing the physiologic aspects of the problem and are identified as the standard of care important in keeping people alive.

After-care coordination and education

Preparing the patient for the next steps is important. This includes:

- Outlining the expectations patients have about next steps
- Coordinating with the entire treatment team including the primary care physician, therapist, pre-existing treating providers and families

Care management

Care management offered through the treatment program or through Blue Cross[®] Coordinated Care can support a holistic treatment plan by helping remove barriers to care and coordinating care across the patient's domains — medical and behavioral health (including substance use disorder treatment).

Collaborative care interventions

Collaborative care interventions by the treatment facility can also help. Here's how this would work:

- The attending physician must be a primary care provider or a specialist.
- A psychiatric consultant needs to be a member of the treatment team.

For more details, refer to [Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care](#).**

Here are some additional things to consider about billing for psychiatric collaborative care services (codes *99492, *99493 and *99494):

- Current limitations related to billing these services for Blue Cross and BCN members are being corrected.
- Member copayments will apply to collaborative care codes until the configuration issues are resolved by Blue Cross and BCN later in 2020.
- The services are more likely to be reimbursed if you bill with only the behavioral health diagnosis. If you bill with only a medical diagnosis, the services will likely not be reimbursed.
- You can bill for collaborative care interventions only once per month, in general. Here are additional rules related to billing for these services:
 - Bill the cumulative case management time each time you bill.
 - Code *99492 (initial visit) can be billed only once in a 12-month period. (If the patient re-engages within the same 12-month period after not being in treatment, you can bill only the *99493 and *99494 codes for that member.)

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- Code *99493 (first 60 minutes in a subsequent month) should be billed for the month following the one in which you billed *99492. It can be billed monthly after that.
- Code *99494 (additional 30 minutes) can be billed once per month, along with *99493.

Refer to [Frequently Asked Questions about Billing Medicare for Behavioral Health Integration \(BHI\) Services](#)** for additional information on billing these codes.

Reasons to use outpatient protocols in treating substance use disorders

Here's why outpatient detoxification and follow-up care are useful in the treatment of substance use disorders>

- These outpatient protocols would help members continue their treatment services for substance use disorders while affording close medical monitoring for worsening conditions
- The increased reliance on MAT would make up for some of the lost social pressure that exists in the inpatient setting while decreasing the risk of adverse outcomes from hospitalization
- The continuing engagement of patients is critical to them reaching and maintaining a disease-free state.
- These protocols are not new; they have evolved from the available literature and from other protocols that have developed over the past several years. The current increase in risk of exposure to infectious diseases has accelerated the need to institute this type of treatment.

Summary of outpatient detoxification and follow-up care protocols

Benefits of outpatient detoxification and follow-up care protocols are:

- Mitigating the negative effects of hospitalization
- Initiating and continuing treatment of the substance use disorder
- Enhancing the family's involvement in the substance use disorder treatment process

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- Increasing utilization of MAT interventions and medical support to accelerate the physiological improvement of the patient and reestablish homeostasis
- Providing flexibility and innovation in medical care during this time of crisis
- Reapportioning residential inpatient personnel to continue to provide services to patients either in the detoxification program or in continued outpatient programming, avoiding staff layoffs
- Using established benefits and processes for payment, billing and utilization management

Barriers to outpatient detoxification and follow-up care protocols are:

- Educating providers that these protocols exist and getting their buy-in to change from traditional treatment sequences
- Operationalizing the program by a treatment provider
- Letting members know about these protocols and getting their buy-in to change from traditional treatment sequences

Targeted outcomes of outpatient detoxification and follow-up care protocols are:

- Having a family assessment early in the treatment and engaging the family in treatment, if possible
- Using MAT for mixed substance use, because it is appropriate that it be used as much as possible. Target: 60-70% of patients on MAT at discharge with patterns related to opioid use disorders
- Using medications that are referred to in the literature as helping patients to decrease cravings and restore homeostasis in 70% of patients that would benefit (that is, medically facilitate treatment)
- Coordinating care with the primary care team on discharge and preferably throughout the course of treatment
- Following up with patients at 30, 60 and 90 days to confirm continued engagement and reengage if not in active treatment
- Decreasing readmission to a target of less than 10% in any facility after completion of a course of treatment

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- On discharge from program, having developed and circulated a substance use disorder advance directive (contingency management/master treatment plan) to continuing treatment team

References:

Yale protocol: <https://medicine.yale.edu/edbup>**

American Society for Addiction Medicine: <https://www.asam.org/>**

Washington Manual of Medical Therapeutics:
<https://www.bing.com/search?q=Washington%20Manual%20of%20medicinal%20therapeutics&form=SWAUA2>**

UptoDate: <https://www.uptodate.com/home>**

New Directions Behavioral Health: <https://www.ndbh.com/>**

Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care:
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710213/>**

Frequently asked questions about billing Medicare for behavioral health integration (BHI) services:
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf>**



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