Louisiana Medicaid | Provider UPDATE

Volume 30, Issue 1 | January/February 2012

Implementation of BAYOU HEALTH Begins

All Providers

Recipient enrollment in BAYOU HEALTH, Louisiana's new approach to delivering and financing health care services for nearly 900,000 recipients of Medicaid and the Louisiana Children's Health Insurance Program (LaCHIP), has begun. The Department of Health and Hospitals (DHH) has contracted with five private health plans (Amerigroup RealSoultions, Community Health Solutions, LaCare, Louisiana Healthcare Connections and UnitedHealthcare Community Plan) to coordinate and manage care for these recipients.

Three of the plans – Amerigroup RealSoultions, LaCare and Louisiana Healthcare Connections – are traditional capitated models that receive a risk-adjusted, per-member per-month fee to provide Medicaid covered services to recipients. The other two plans – Community Health Solutions and UnitedHealthcare Community Plan – are Enhanced Primary Care Case Management models, in which providers are responsible for offering primary care and coordinating members' services in exchange for a care management fee paid per recipient in the network.

Implementation of BAYOU HEALTH is being phased in during the next several months based on three geographic service areas (GSAs): February 1, 2012 for recipients in GSA A (New Orleans and Northshore regions), April 1, 2012 for recipients in GSA B (Capital Area, South Central Louisiana and Acadiana regions), and June 1, 2012 for recipients in GSA C (Southwest Louisiana, Central Louisiana and North Louisiana).

Eligible recipients will have an enrollment period to select their health plans. The BAYOU HEALTH Enrollment Center is sending all eligible recipients an enrollment packet that contains information about the five health plans and the services/benefits included with each. BAYOU HEALTH staff has scheduled numerous immersion events in each area of Louisiana, where recipients will have an opportunity to talk to enrollment agents and select a health plan. Recipients can also enroll online at www.bayouhealth.com, complete the enrollment forms in their enrollment packets, or call toll-free 1-855-BAYOU4U (1-855-229-6848) to enroll with an enrollment specialist or to use the automated phone enrollment system. Recipients who do not select a plan will be auto-enrolled.

There will be a 90-day window after each GSA implementation for recipients to change health plans. There will be an annual enrollment period after the intial 90-day window for recipients to change plans; however, recipients can change health plans at any time, if they can show good cause.

Most of the current Medicaid recipients will transition to BAYOU HEALTH. However, recipients of Medicaid waiver services (or recipients on the waiver registry), hospice care, LaCHIP Affordable Plan, Medicare (dual eligibles), Louisiana Health Insurance Premium Payment (LaHIPP), family planning services (TAKE CHARGE), Greater New Orleans Community Health Connection (GNOCHC) or recipients in long-term care centers or developmental disability centers will not be included in the transition.

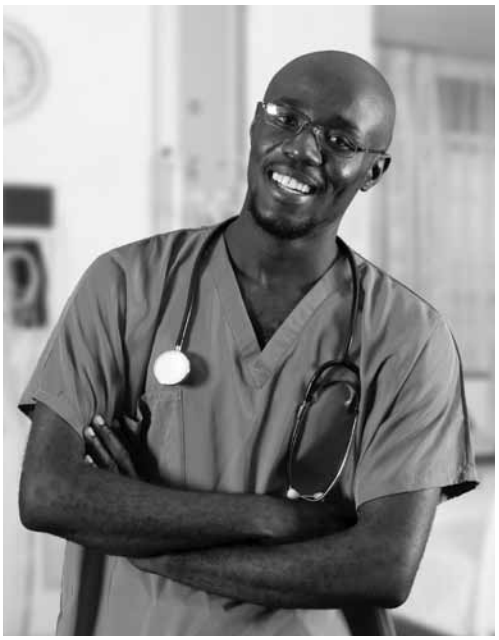
Providers have the option to join as many BAYOU HEALTH plans as they wish as well as remain in the regular Medicaid fee-for-service program to treat their patients who will not be included in BAYOU HEALTH.

Although providers are prohibited from directly steering patients toward a particular BAYOU HEALTH plan, they are allowed to let their Medicaid patients know which plan(s) they have joined. The BAYOU HEALTH team has created a flyer that providers can distribute to their Medicaid patients that easily identifies the names of all the BAYOU HEALTH plans in which they will participate. The flyer can be downloaded at www.MakingMedicaidBetter.com through the Providers tab. Providers should also be prepared to inform recipients who are not part of BAYOU HEALTH whether they will continue as a Medicaid fee-for-service provider.

Primary care providers who are currently part of DHH's CommunityCARE program can enter into a voluntary agreement with DHH to assist in BAYOU HEALTH outreach. Interested providers should contact Damiane Ricks at (225) 342-7877 or damiane.ricks@la.gov to fill out a CommunityCARE/BAYOU HEALTH Outreach Agreement and see the conditions that apply to this outreach.

For the latest information about BAYOU HEALTH, visit: www.MakingMedicaidBetter.com or the enrollment website, www.bayouhealth.com. To share your comments or ask questions, email bayouhealth@la.gov.

Table of Contents



Avoid Hiring or Employing Excluded Individuals

All Providers

As a condition of participation in the Louisiana Medicaid Program, providers are responsible for ensuring that current as well as potential employees and/or contractors have not been excluded from participation in the Medicaid or Medicare Program by Louisiana Medicaid and/or the Office of Inspector General (OIG). Providers who employ or contract with excluded individuals or entities may be subject to penalties of $10,000 for each item or service the excluded individual or entity furnished.

Providers should check the following two websites prior to hiring or contracting with an individual or entity and should routinely check the websites for determining the exclusion status of current employees and contractors. All current and previous names used such as first, middle, maiden, married or hyphenated names and aliases for **all owners, employees and contractors** should be checked.

- http://exclusions.oig.hhs.gov/search.aspx
- http://www.epls.gov/epls/search.do

If an individual's or entity's name appears on either website, this person or entity is considered excluded and is barred from working with Medicare and/or the Louisiana Medicaid Program in any capacity. The provider must notify the Department of Health and Hospitals with the following information:

- Name of the excluded individual or entity, and
- Status of the individual or entity (applicant or employee/contractor).

If the individual or entity is an employee or contractor, the provider should also include the following information:

- Beginning and ending dates of the individual's or entity's employment or contract with the agency,
- Documentation of termination of employment or contract, and
- Type of service(s) provided by the excluded individual or entity.

These findings should be reported to:

Department of Health and Hospitals
Program Integrity - Special Investigations Unit
P. O. Box 91030
Baton Rouge, LA 70821-9030
Fax: (225) 219-4155

Medicaid providers should review the information provided in the SPECIAL ADVISORY BULLETIN titled "The Effect of Exclusion from Participation in Federal Healthcare Programs" at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/effected.htm.

Sections E, F, and G of the bulletin explain the prohibition against hiring excluded individuals or entities and the fines and penalties involved when an excluded individual or entity is hired or contracted.

Remittance Advice Corner

All Providers

The following is a compilation of messages that were recently transmitted to providers through Remittance Advices (RA):

Attention Hospital, Physician and Outpatient Radiology Providers: Effective January 1, 2012 for the Radiology Utilization Management Program (RUM)

One new CPT code has been established for Computed Tomographic Angiography (CTA) study of the abdomen and pelvis. The code is 74174. This code becomes effective January 1, 2012, and is included in the Radiology Utilization Management (RUM) program. This code will require prior authorization (PA). The code description is listed below:

74174 – Computed tomographic angiography; abdomen and pelvis; with contrast material(s), including non-contrast images, if performed, and image post-processing

If prior authorization (PA) is not obtained for this procedure per the current RUM guidelines, then the procedure will not be payable by Louisiana Medicaid. For further information regarding RUM policy and procedure please visit www.lamedicaid.com.

Attention All Providers Submitting or Receiving 5010 Claim Transactions (820, 835, 837D, 837I, and 837P)

In order to allow additional time for providers to test, Molina will continue to accept Version 4010 electronic claims transactions after January 1, 2012. CMS has announced that they will not initiate enforcement action with respect to any HIPAA covered entity that is not in compliance with the implementation date for the ASC X12 VERSION 5010 STANDARDS until March 31, 2012.

In preparation for 5010 implementation, providers should continue to work with their billing entities to ensure that they will be ready for submittal prior to March 31, 2012.

For more detailed information, the revised 5010 EDI Companion Guides are published on the Louisiana Medicaid Website, under the 5010 link on the main page.

Access the website on a regular basis for 5010 implementation updates and reminders.

Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan Now Offers New Service to Recipients

Dental Providers

Effective February 1, 2012, Louisiana Medicaid began providing dental benefits to recipients of the LaCHIP Affordable Plan (LAP), a cost-sharing health insurance plan for Louisiana's uninsured children under 19 years of age. LAP, which differs from LaCHIP, provides recipients with major medical and prescription benefits through Louisiana's Office of Group Benefits (OGB) Preferred Provider Organization (PPO).

However, Louisiana Medicaid, not OGB, is administering the dental benefits and claims processing for LAP recipients. Therefore, providers **should not use** a recipient's PPO medical card with OGB/Catalyst to file dental claims on these recipients. Inquiry about a child's eligibility for dental benefits should be made by calling Louisiana Medicaid's Recipient Eligibility Verification System (REVS) at 1-800-766-6323.

Providers should contact the Medicaid Customer Service Unit at 1-877-252-2447 for assistance with questions regarding this change.

Online Medicaid Provider Manual Chapters

All Providers

The following Medicaid Provider Manual Chapters are available on the Louisiana Medicaid website at www.lamedicaid.com under the "Provider Manual" link. This list will be updated periodically as other Medicaid program chapters become available online.

- Administrative Claiming
- Adult Day Health Care Waiver
- Ambulatory Surgical Centers
- American Indian 638 Clinics
- Children's Choice Waiver
- Dental
- Durable Medical Equipment
- Elderly and Disabled Adult Waiver
- End Stage Renal Disease
- Family Planning Clinics
- Family Planning Waiver (Take Charge)
- Federally Qualified Health Centers
- General Information and Administration
- Greater New Orleans Community Health Connection (GNOCHC)
- Home Health
- Hospitals
- ICF/DD
- Medical Transportation
- Mental Health Clinics
- Mental Health Rehabilitation
- Multi-Systemic Therapy
- New Opportunities Waiver (NOW)
- Pediatric Day Health Care
- Personal Care Services
- Pharmacy
- Professional Services
- Psychological Behavioral Services
- Residential Options Waiver
- Rural Health Clinics
- Supports Waiver
- Vision (Eye Wear)

Revisions have been made to the following Medicaid Provider Manual Chapters. Providers should review these revisions in their entirety at www.lamedicaid.com under the "Provider Manual" link:

Manual Chapter	Section	Date of Revision
Children's Choice Waiver	14.4 – Service Access and Authorization	12/15/2011
Children's Choice Waiver	Table of Contents 14.4 – Service Access and Authorization 14.5 – Provider Requirements 14.11 – Support Coordination	01/26/2012
Durable Medical Equipment	Table of Contents 18.1 - Services and Limitations 18.2 – specific coverage Criteria 18.4 – Provider Requirements 18.5 – Prior Authorization 18.6 – claims Related Information Appendix F – Covered Service/Codes	02/01/2012
General Information and Administration	Table of Contents 1.4 – General Claims Filing	12/15/2011
Greater New Orleans Community Health Connection	47.5 – Reporting Requirements	01/25/2012
Hospital Services	25.6 - Prior Authorization 25.8 – Claims Related Information	02/01/2012
Medical Transportation	10.3 – NEMT Provider Requirements	01/01/2012
New Opportunities Waiver	32.1 – Covered Services Appendix D - Forms	12/15/2011

Pharmacological Management of Moderate to Severe Alcohol Withdrawal

Louisiana Drug Utilization Review (LADUR) Education

Shawn M. Manor, PharmD, BCPS
Associate Professor
College of Pharmacy
University of Louisiana at Monroe

Introduction

Alcoholism is a very common issue that most healthcare providers have faced. Current estimates show that approximately 8.2 million Americans are alcohol dependent with a significant portion of those suffering from episodes of withdrawal significant enough to require medical management.[1] Symptoms vary from minor, such as headaches and anxiety, to severe, such as tonic-clonic seizures. (Table 1) It is unclear why some patients exhibit more severe symptoms, but length of alcohol abuse appears to play a role. [2]

Alcohol enhances inhibitory tone by gamma-aminobutyric acid (GABA) modulation and inhibits excitatory tone simultaneously.[2] Chronic alcohol use desensitizes receptors to GABA which is the reason alcoholic-dependent patients maintain arousal when alcohol concentrations would be expected to cause lethargy. Excitatory amino acids (primarily glutamate) are inhibited also and there is an adaptive response which makes receptors more sensitive to glutamate.[3] Chronic alcohol use maintains this new balance which is interrupted when alcohol is discontinued. The result is the potential for moderate to severe and potentially lethal symptoms associated with withdrawal.

Manifestations

Symptoms of withdrawal may appear as soon as 6 hours from the last drink and may manifest even when blood alcohol levels are present. Patients generally show the same spectrum of symptoms with each successive episode of withdrawal. Without escalation of withdrawal, symptoms usually resolve within 24-48 hours.[4] (Table 1)

Alcoholic hallucinosis typically occurs within the first 12-24 hours after cessation, with resolution by 48 hours. Alcoholic hallucinosis is commonly confused with delirium tremens (DT) but is distinctly different. Hallucinations are usually visual and vital signs are typically normal while patients in DT tend to have elevated blood pressure and heart rate.[4] (Table 1)

Seizures associated with withdrawal usually occur in the first 12-48 hours after cessation but may occur sooner and are usually seen in patients with long histories of alcohol abuse. The tonic-clonic seizures appear as short bursts during a brief interval rarely manifesting as recurrent seizures or status epilepticus.[4] (Table 1)

Delirium tremens (DT) is the most severe of the manifestations of withdrawal and is characterized by disorientation, agitation, diaphoresis, hypertension and tachycardia. Symptoms of DT typically present between 48 and 72 hours after last ingestion of alcohol and may last for up to 7 days.[4] Up to 5% of patients going into withdrawal will have DTs. Patients in DT may have abnormal cardiac indices, impaired oxygen delivery and hyperventilation. This can cause arterial pH to rise and may lead to respiratory alkalosis which can result in serious decreases in cerebral blood flow.[5] The mortality rate for all patients with DT is approximately 15% but it can be as much as 25% in patients with major associated illnesses such as hepatitis, pneumonia or pancreatitis.[6]

Risk factors for Severe Symptoms and DT[7]

- Duration of alcoholism
- Prior detoxification
- Previous DT
- Concurrent illness
- Length of time between last drink and presentation (Patients presenting in the first 2 days after drinking are less likely to enter into DT than patients presenting after 2 days.)
- Older age

General Management

Treatment should be centered on alleviating symptoms and any metabolic disturbances. Fluid and electrolyte imbalances are common due to hyperthermia, diaphoresis, tachypnea and vomiting. Hypokalemia and hypomagnesemia predispose DT patients to arrhythmias; therefore, potassium and magnesium must be replaced as needed and frequently monitored. Thiamine and glucose should be administered to prevent or treat Wernicke's encephalopathy and patients should also receive folic acid containing multivitamins. Nutritional support is important in alcoholic patients due to poor eating habits and the hypermetabolic state of withdrawal. During the early stages of withdrawal (first 24-48 hours), it may be best to keep the patient NPO to avoid aspiration. Intravenous dextrose is sufficient for these patients, but if they are unable to eat for more than a day or two, an alternative source of nutrition may be needed (i.e. enteral, parenteral). [5]

Sedation

The goal for patients with low to moderate risk of withdrawal symptoms is to sedate the patient to the point of being calm but alert. Patients who are at high risk for developing severe withdrawal symptoms should be more aggressively sedated to the point that the patient is no longer delirious.[5]

Benzodiazepines

Benzodiazepines (BZDs) are an ideal pharmacologic treatment option for alcohol withdrawal syndrome due to the cross-tolerance to alcohol. The effect is seen through the stimulation of GABA receptors which decreases neuronal activity and sedation.[5] BZDs are generally safe and effective in treating or preventing seizures, delirium and psychomotor agitation associated with withdrawal. BZDs commonly used are chlordiazepoxide, diazepam, lorazepam and oxazepam. Chlordiazepoxide and diazepam are long acting while lorazepam and oxazepam are intermediate acting. Selection is made based on the pharmacokinetic properties as well as administration route. Use of long-acting BZDs with active metabolites usually results in a more even recovery with a decreased possibility of seizures.[4]

Common adverse reactions associated with BZDs include fatigue, ataxia, memory impairment, drowsiness and irritability which can be confused with the withdrawal syndrome. Oversedation is a significant concern especially with the long-acting BZDs with active metabolites in the setting of significant hepatic disease. Patients should be strictly monitored and BZDs should be tapered down according to symptoms and level of arousal.[5]

Chlordiazepoxide (Table 2)
Chlordiazepoxide is a long-acting BZD available only in oral formulations. It is extensively hepatically metabolized and has an active metabolite. Elimination half-life is 6-25 hours but may be slightly longer with end stage renal disease (ESRD). Patients with significant liver disease may see the elimination half-life extended to an average of 30-63 hours.[5]

Pharmacological Management of Moderate to Severe Alcohol Withdrawal

Continued from page 5

Diazepam (Table 2)
Diazepam is a long-acting BZD which is available in oral, rectal and parenteral formulations. Diazepam is also extensively hepatically metabolized and has an elimination half-life of 20-50 hours which is increased in the elderly and patients with significant hepatic disease. Diazepam does have an active metabolite.[5]

Oxazepam (Table2)
Oxazepam is an intermediate-acting BZD only available in oral formulations. Although oxazepam is extensively hepatically metabolized, it does not have an active metabolite.[5] Since it lacks an active metabolite, it may be a better option for those patients with significant hepatic disease or the elderly. Half-life elimination for oxazepam is approximately 3-6 hours.[5]

Lorazepam (Table 2)
Lorazepam is an intermediate-acting BZD available in oral and parenteral formulations. Like oxazepam it is extensively hepatically metabolized and has no active metabolite which makes it another alternative to the long-acting BZDs in hepatically impaired patients. Lorazepam has an elimination half-life in adults of 13-16 hours but it extends to 30-70 hours in patients with ESRD.[5]

Anticonvulsants

The use of alternatives to BZDs is not extensively supported by clinical evidence. Anticonvulsants are being studied mostly in the realm of out-patient detoxification. One of the benefits of using anticonvulsants is the relative lack of both abuse potential and additive sedative effect with alcohol. Anticonvulsants have not been shown to significantly reduce seizures associated with alcohol withdrawal.[1]

Carbamazepine
The use of carbamazepine in alcohol withdrawal is not as clear as BZD's. Trials have shown that carbamazepine can be substituted for BZDs for mild withdrawal symptoms, but its role seems to be limited to ambulatory alcohol detoxification. Carbamazepine may also decrease cravings for alcohol after withdrawal.[7,8] Carbamazepine is extensively hepatically metabolized and caution must be used in patients with significant liver disease. [5]

Phenytoin
The use of phenytoin has not shown to be effective in alcohol withdrawal nor has it been shown to be effective in preventing withdrawal seizures. Since alcoholic withdrawal seizures are mostly self-limited they do not require the constant use of anticonvulsants. Phenytoin may be beneficial in patients with an underlying seizure condition, but again, phenytoin does not have a role in alcohol withdrawal.[9,10]

Other Medications

Propofol
Propofol acts by opening chloride channels in the absence of GABA and will further sedate patients in addition to BZDs. Propofol is currently used in patients with refractory DTs despite the use of high dose BZDs. Patients who are given propofol should be monitored in the ICU as they will require intubation.[5,11]

Ethanol
Ethanol has been studied for use in alcohol withdrawal but has not been shown to be superior to BZDs and its role is dubious as it is difficult to titrate and because of the associated adverse effects.[12,13]

Baclofen
Baclofen is a GABA-B receptor agonist used mainly to control muscle spasticity. Baclofen's role is not clearly defined at this point. Overall, studies have not shown baclofen to be useful in moderate to severe withdrawal; however, one study did show it to be as effective as diazepam for controlling mild to moderate symptoms which may relegate it to the outpatient setting.[14]

Antipsychotics
Antipsychotics such as haloperidol lower the seizure threshold and should not be routinely used to treat withdrawal symptoms.[12] Antipsychotics should be considered only for those individuals with decompensated thought disorders (i.e. schizophrenia). Due to QT prolongation associated with antipsychotics, an ECG should be performed and all electrolyte abnormalities should be corrected prior to initiation.[5]

Beta blockers and alpha-2 agonists
These agents can reduce minor symptoms related to withdrawal but do not prevent the progression to seizures or DT. Clonidine has been used adjunctively for reduction in noradrenergic symptoms but caution should be used with alpha-2 agonists/beta-blockers since they can potentially mask blood pressure and heart rate changes and confound patient assessment.[12,15,16]

Administration

Most patients with moderate to severe withdrawal symptoms will require intravenous (IV) therapy; all patients with seizures and DT must be treated parenterally. Intravenous administration assures rapid onset of action and absorption; therefore, all patients at risk of severe symptoms should have IV access.[5]

Dosing

Medications are titrated based on the patient's current status and their ability to manage DT symptoms. For example, a younger patient with no comorbid conditions will not need as much sedation as an older patient with heart failure. Medically compromised patients should be sedated more heavily to reduce the impact of a severe withdrawal syndrome.[5]

The idea for dosing is to administer enough medication to induce the appropriate level of sedation. There are multiple dosing options both parenterally and orally. (Table 2) Significant titration of parenteral BZDs may be necessary in severe withdrawal and large doses can be used.

Fixed Schedule Dosing

As the name implies, fixed scheduled dosing involves the administration of medications around the clock regardless of the presence of symptoms. For patients with moderate symptoms and a functioning gut, chlordiazepoxide, diazepam and lorazepam are recommended. Doses are titrated to achieve the appropriate level of sedation and then tapered over 2-4 days.[12] (Table 3)

Pharmacological Management of Moderate to Severe Alcohol Withdrawal

Continued from page 6

Symptom-triggered Dosing

Current literature supports the use of symptom-triggered dosing which requires the administration of medication only in the setting of symptoms. One major study looked at the use of scheduled versus symptom-triggered chlordiazepoxide for the treatment of moderate to severe alcohol withdrawal in the hospital setting. Patients in the symptom-triggered group used less medication and had a shorter treatment period. The symptom-triggered group on average required 100 mg versus an average of 425 mg in the fixed-schedule group. The median treatment period in the symptom-triggered group was 9 hours compared to 68 hours in the fixed-schedule group.[12,17]

The use of symptom-triggered dosing requires a validated assessment tool. One widely used tool is the Clinical Institute Withdrawal Assessment for Alcohol Scale (CIWA-Ar). When using the CIWA-Ar, evaluations are carried out every 10 to 15 minutes in those patients receiving IV BZDs with severe symptoms or at high risk for developing severe symptoms. When severe symptoms have diminished, evaluations can be reduced to every hour. Once stabilized or for those patients with mild to moderate symptoms, assessment should be carried out every 4 hours. Mild withdrawal symptoms correlate to CIWA-Ar score of 8 or less. Scores of 9-15 correlate to moderate symptoms, and scores greater than 15 correlate to severe symptoms. Most symptom-triggered dosing regimens call for administration of BZDs only when the CIWA-Ar score is above 8. (Table 3) One issue to consider when using the CIWA-Ar for patient assessment is that it requires the patient to be conscious and lucid enough to provide responses to the assessment questions.[4,12]

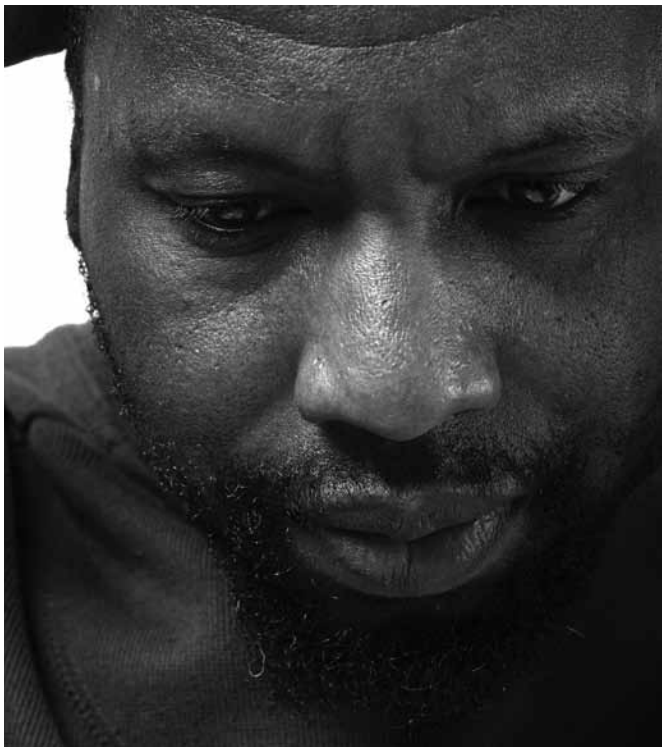
Conclusion

Alcohol withdrawal is a serious and potentially fatal condition that should be treated immediately and aggressively. BZDs are the drug of choice for withdrawal due to the cross-tolerance with alcohol and ease of titration. The two schools of thought with regards to administering BZDs are around the clock (fixed dosing schedule) and symptom-triggered therapy. The use of symptom-triggered therapy allows for a decrease in the total dose of BZDs as well as overall treatment length. Reducing the use of BZDs decreases the risk of adverse drug effects associated with treating alcohol withdrawal especially considering the large portion of patients with significant liver disease.

Table 1
Symptoms of Alcohol Withdrawal Syndrome [4]

Symptoms	Time of appearance after cessation of alcohol use
Minor symptoms: insomnia, tremulous, mild anxiety, GI upset, headache, diaphoresis, palpitations, anorexia	6 – 12 hours
Alcoholic hallucinosis: visual, auditory or tactile hallucinations	12 – 24 hours*
Withdrawal seizures: generalized tonic-clonic	24 – 48 hours**
Alcohol withdrawal delirium (DT): hallucinations (predominantly visual), disorientation, tachycardia, hypertension, low-grade fever, agitation, diaphoresis	48 – 72 hours***

*Symptoms generally resolve within 48 hours
**Symptoms reported as early as two hours after cessation
***Symptoms peak at five days



Pharmacological Management of Moderate to Severe Alcohol Withdrawal

Continued from page 7

Table 2
Benzodiazepines used for Moderate to Severe Alcohol Withdrawal [5]

Drug	Adult Dose		Precautions / Warnings / Adverse Effects
	Oral	IV	
Chlordiazepoxide	50-100mg to start, repeat in 2-4 hours PRN (max 300mg/24hrs)	N/A	Sedation, lethargy, caution with hepatic impairment
Diazepam	Moderate symptoms: 10 mg 3-4 times in first 24 hours, then decrease to 5 mg 3-4 times/day PRN	Moderate to Severe symptoms: 5-10 mg every 5-10 minutes until appropriately sedated	Sedation, lethargy, caution with hepatic impairment
Lorazepam	Moderate symptoms: 2 mg every 6 hours for 4 doses, then 1 mg every 6 hours for 8 doses	Withdrawal delirium : 1-4 mg every 5-15 mg until calm, then every hour as needed for appropriate sedation	Sedation, lethargy, caution with hepatic impairment IV formulations contain propylene glycol; toxicity may occur at doses ≥ 6 mg/hr for 48 hours or more
Oxazepam	Moderate symptoms: 15-30 mg 3-4 times/day PRN	N/A	Sedation, lethargy, caution with hepatic impairment

Table 3
Moderate to Severe Withdrawal Treatment Examples [12]

Monitoring

- Assess patient with CIWA-Ar *every 4-8 hours until score < 8-10 for 24 hours

Symptom Triggered

- Administer 1 of the following BZDs when CIWA-AR score is ≥ 8-10
  - Chlordiazepoxide 50-100 mg
  - Diazepam 10-20 mg
  - Lorazepam 2-4 mg
- Repeat CIWA-AR 1 hour after each dose to assess for further administration of medication

Fixed Schedule

- Chlordiazepoxide 50 mg every 6 hours for 4 doses, then 25 mg every 6 hours for 8 doses
- Diazepam 10 mg every 6 hours for 4 doses, then 5 mg every 6 hours for 8 doses
- Lorazepam 2 mg every 6 hours for 4 doses, then 1 mg every 6 hours for 8 doses
- Administer additional medication as needed when CIWA-Ar ≥ 8-10

Note: Other BZDs may be used at equivalent doses

*CIWA-Ar- Alcohol Withdrawal Assessment Scoring Guidelines

Pharmacological Management of Moderate to Severe Alcohol Withdrawal

Continued from page 8

References

1. Kosten TR, O'Connor PG. Management of drug and alcohol withdrawal. N Engl J Med 2003; 348:1786-1795.
2. Mihic SJ, Ye Q, Wick MJ, et al. Sites of alcohol and volatile anaesthetic action on GABA(A) and glycine receptors. Nature 1997; 389:385.
3. Tsai G, Gastfriend DR, Coyle JT. The glutamatergic basis of human alcoholism. Am J Psychiatry 1995; 152:332.
4. Bayard M, McIntyre J, Hill K, et al. Alcohol withdrawal syndrome. AmFam Physician 2004; 69:1443-50.
5. UpToDate 19.3. Available at http://www.uptodate.com. Accessed December 2, 2011.
6. Abraham E, Shoemaker WC, McCartney SF. Cardiorespiratory patterns in severe delirium tremens. Arch Intern Med 1985; 145:1057.
7. Saitz R, O'Malley SS. Pharmacotherapies for alcohol abuse. Withdrawal and treatment. Med Clin North Am 1997; 81:881.
8. Ait-Daoud N, Malcolm RJ Jr, Johnson BA. An overview of medications for the treatment of alcohol withdrawal and alcohol dependence with an emphasis on the use of older and newer anticonvulsants. Addict Behav 2006; 31:1628.
9. Alldredge BK, Lowenstein DH, Simon RP. Placebo-controlled trial of intravenous diphenylhydantoin for short-term treatment of alcohol withdrawal seizures. Am J Med 1989; 87:645.
10. Chance JF. Emergency department treatment of alcohol withdrawal seizures with phenytoin. Ann Emerg Med 1991; 20:520.
11. McCowan C, Marik P. Refractory delirium tremens treated with propofol: a case series. Crit Care Med 2000; 28:1781.
12. Mayo-Smith MF. Pharmacological management of alcohol withdrawal. A meta-analysis and evidence-based practice guideline. American Society of Addiction Medicine Working Group on Pharmacological Management of Alcohol Withdrawal. JAMA 1997; 278:144.
13. Hodges B, Mazur JE. Intravenous ethanol for the treatment of alcohol withdrawal syndrome in critically ill patients. Pharmacotherapy 2004; 24:1578.
14. Addolorato G, Leggio L, Abenavoli L, et al. Baclofen in the treatment of alcohol withdrawal syndrome: a comparative study vs diazepam. Am J Med 2006; 119:276. e13.
15. Adinoff B. Double-blind study of alprazolam, diazepam, clonidine, and placebo in the alcohol withdrawal syndrome: preliminary findings. Alcohol ClinExp Res 1994; 18:873.
16. Prater CD, Miller KE, Zylstra RG. Outpatient detoxification of the addicted or alcoholic patient. AmFam Physician 1999; 60:1175.
17. Saitz R, Mayo-Smith MF, Roberts MS, et al. Individualized treatment for alcohol withdrawal. A randomized double-blind controlled trial. JAMA 1994; 272:519.

MOLINA®
Medicaid Solutions

Provider Relations
P.O. Box 91024
Baton Rouge, LA 70821

7553MMS0212

For information or assistance, call us!

Provider Enrollment	(225) 216-6370
Prior Authorization	
Home Health/EPSDT - PCS	1-800-807-1320
Dental	1-866-263-6534 1-504-941-8206
DME & All Other	1-800-488-6334 (225) 928-5263
Hospital Pre-Certification	1-800-877-0666
Provider Relations	1-800-473-2783 (225) 924-5040
REVS Line	1-800-776-6323 (225) 216-REVS (7387)
Point of Sale Help Desk	1-800-648-0790 (225) 216-6381

General Medicaid Eligibility Hotline	1-888-342-6207
LaCHIP Enrollee/Applicant Hotline	1-877-252-2447
MMIS/Claims Processing/Resolution Unit	(225) 342-3855
MMIS/Recipient Retroactive Reimbursement	(225) 342-1739 1-866-640-3905
Medicare Savings Program Medicaid Purchase Hotline	1-888-544-7996
KIDMED & CommunityCARE AHS	1-800-259-4444
For Hearing Impaired	1-877-544-9544
Pharmacy Hotline	1-800-437-9101
Medicaid Fraud Hotline	1-800-488-2917