Overview

Outpatient acupuncture may be used as an ancillary treatment during detoxification or post-detoxification. The purpose of this guideline is to outline the level of care criteria, including the admission, continued stay, discharge, and exclusion criteria for the Acupuncture Detox Level of Care.

Clinical Guideline Coverage Criteria

Admission Criteria

The Plan considers outpatient acupuncture detox level of care as reasonable and medically necessary when ALL of the following are met:

1. Have a history of a substance use disorder; **and**
2. Exhibit symptoms of withdrawal and disordered behavior that interfere with activities of daily living but not to a degree that pose a risk to themselves or others; **and**
3. Have adequate support systems to allow for success in an outpatient setting

Continued Treatment Criteria
The Plan considers continued outpatient acupuncture detox level of care as reasonable and medically necessary when **ALL** of the following are met:

1. Member continues to meet medical necessity criteria, and a different level of care is not appropriate; **and**
2. Member experiences symptoms of such intensity that, if discharged, would require a more intensive level of care; **and**
3. Member receives individualized and specific treatment planning, including provider’s orders, special procedures, contraindications, and other medications; **and**
4. Member has family/guardian(s) participating in treatment, where appropriate; **and**
5. Member receives services in a structured and goal-directed manner

**Practitioners Must comply with the following:**

1. Attempt or rule out medication trials, if inappropriate; **and**
2. Make sure the enrollee gets different treatment(s) if symptoms change, or if they make or fail to make progress; **and**
3. Have strategies in place to address any possible treatment plan changes; **and**
4. Have a treatment plan that documents treatment coordination and coordination with state agencies, if involved

**Discharge Criteria**

The Plan considers discharge from outpatient acupuncture detox level of care as reasonable and medically necessary when **ALL** of the following are met:

1. No longer meet medical necessity criteria and/or meet criteria for a different level of care (higher or lower); **and**
2. Meet individual treatment plan and goals; **and**
3. Have a support system who agrees to follow through with patient care, and are able to be in a less-restrictive environment
4. Have all appropriate community-based linkages in place
5. Withdraw their consent for treatment, or their authorized representative withdraws consent
6. Do not appear to be participating in the treatment plan, are not making progress toward goals, and there is little to no expectation of any progress

**Limitations**

The Plan considers outpatient acupuncture detox level of care as not medically necessary for Members who are actively suicidal or homicidal or who have a co-morbid psychiatric diagnosis that requires inpatient treatment.

**Codes**

The following code(s) are associated with this service:

**Table 1: CPT/HCPCS Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>H0014</td>
<td>Alcohol and/or drug services; ambulatory detoxification</td>
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**References:**


**Approval And Revision History**

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC), renewed without changes
Subsequent endorsement date(s) and changes made:

- November 4, 2020: Fax number for Unify updated
- September 15, 2021: Reviewed by IMPAC, renewed without changes
- April 5, 2022: Template updated
- September 21, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment, or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.