Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Behavioral Health: Opioid Treatment Services (Methadone Maintenance) Level of Care**

Effective: November 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below.	Yes ☐ No ☒
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care – A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

Overview

Please note that there is no out-of-network benefit for these plans. To obtain coverage out-of-network for any service, prior authorization is required. Please refer to the Out-of-Network Coverage at the In-Network Level of Benefits Medical Necessity Guideline (MNG) for information regarding when coverage for out-of-network services will be authorized.

Methadone treatment services include daily administration of methadone to patients addicted to opiates, combined with regular counseling, medical screening, urine testing, HIV/AIDS education, care management, and other appropriate services. Treatment goals include eliminating opiate use and IV drug use, evaluating, and eliminating the use or abuse of alcohol or other drugs, improving The Plan Members' health status, and improving level of functioning. Plan Members may get methadone treatment on a short-term (detoxification) basis and a long-term basis, though the duration of service will vary depending on individual need. This level of care may be provided to Members who are addicted to opiates (as outlined in federal regulations) for at least one year who have not responded well to other treatment interventions. Tufts Health Plan allows daily methadone dosing, and individual, family, or group counseling as clinically indicated.

Clinical Guideline Coverage Criteria

Admission Criteria

The Plan considers admission to opioid treatment services as reasonable and medically necessary when **ALL** of the following are met:

1. Have an active DSM-V Axis I diagnosis of opiate dependence; **and**
2. Have evident and documented signs and symptoms of opioid withdrawal; **and**
3. Meet all appropriate Drug Enforcement Agency (DEA) and Department of Public Health (DPH) regulations; **and**
4. Have a sufficiently acute risk of relapse or continued opiate dependence and require a medication prophylaxis, regular counseling, and individualized urine monitoring; **and**
5. Have biomedical conditions and opiate addiction-based complications that require medical monitoring and skilled care most effectively managed at this level of care.

The following are additional narcotics treatment guidelines:

1. Members who previously received methadone treatment for additional services without evidence of current physical dependence and/or recent relapse may be re-admitted if there is a documented risk for opiate use and/or recent relapse.
2. Members who are younger than 18 years of age may be admitted to this level of care if they are pregnant or have two documented unsuccessful attempts at short-term detoxification or drug-free treatment within the previous 12 months.

Continued-Stay Criteria

The Plan considers continuation of opioid treatment services as reasonable and medically necessary when **ALL** of the following are met:

1. Continue to meet admission criteria, and a different level of care is not appropriate; **and**
2. Experience symptoms of such intensity that, if discharged, would require a more intensive level of care; **and**
3. Receive individualized and specific treatment planning, including, but not limited to provider's orders, special procedures, contraindications, and other medications; **and**
4. Have family/guardian participating in treatment, as appropriate to get services in a structured and goal-directed manner

Note: Practitioners must abide by the following:

1. Consider medication trials, as appropriate
2. Ensure that Members receive different treatment(s) if symptoms change, or if they make or fail to make progress
3. Have strategies in place to address any possible treatment plan changes
4. Have a treatment plan that documents treatment coordination and coordination with state agencies, caregivers and family, as appropriate
5. Attempt to discharge or move to a lower level of care

Discharge Criteria

The Plan considers discharge from opioid treatment services as reasonable and medically necessary when **ONE** of the following are met:

1. Achieve treatment goals; **or**
2. Have a support system that agrees to follow through with care, and are able to be in a less- restrictive environment; **or**
3. Have all appropriate community-based linkages in place and functioning; **or**
4. Withdraw consent for treatment, or a parent/guardian withdraws such consent; **or**
5. Do not appear to be participating in the treatment plan, or are not making progress toward goals, with little to no expectation for progress

Limitations

The Plan will not cover opioid treatment services when Members meets any of the following:

1. Members have medical problems that require hospitalization and/or an illness that would interfere with methadone treatment
2. Members who are experiencing acute withdrawal from opioids, sedative hypnotics, or stimulant drugs

Codes

The following code(s) are associated with this service

Table 1: CPT/HCPCS Codes

Code	Description
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0004 with TF modifier	Behavioral health counseling and therapy, per 15 minutes (intermediate level of care)
H0005 with HQ modifier	Alcohol and/or drug services; group counseling by a clinician
T1006 with HR modifier	Alcohol and/or substance abuse services, family/couple counseling

References:

1. American Society of Addiction Medicine (ASAM) Patient Placement Criteria, second edition-revised
2. MassHealth Contract, 2016
3. Commonwealth Care Contract, 2012
4. Medical Security Plan Contract, 2012
5. SAMHSA TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs
6. Code of Federal Regulations, Title 42, Part 8, Opioid Treatment Programs Certification (42 CFR, Part 8)

Approval And Revision History

October 21, 2020: Reviewed by the Medical Policy Approval Committee (MPAC) and 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
- August 16, 2023: Reviewed by MPAC, renewed without changes, template update effective November 1, 2023
- November 2023: Unify name changed to One Care effective January 1, 2024
- September 19, 2024: Reviewed and approved by the Joint Medical Policy and Health Care Services Utilization Management Committee, no changes
- September 19, 2024: Reviewed by MPAC, renewed without changes effective November 1, 2024

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.