Medical Necessity Guidelines:
Behavioral Health – Acupuncture Detoxification Level of Care

Effective: October 16, 2019

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	**Yes ☐ No ☒**

Applies to:
COMMERCIAL Products
☐Tufts Health Plan Commercial products; Fax: 617.972.9409
☐Tufts Health Freedom Plan products; Fax: 617.972.9409
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
- Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

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 COVERAGE CRITERIA

In order to be covered for Outpatient Acupuncture Detox level of care, Tufts Health Plan Members must meet the following guidelines:

- Have a history of a substance use disorder
- 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
- Have adequate support systems to allow for success in an outpatient setting

Continued Treatment Criteria

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

Practitioners must:

- Attempt or rule out medication trials, if inappropriate
- Make sure the enrollee gets different treatment(s) if symptoms change, or if they make or fail to make progress
- Have strategies in place to address any possible treatment plan changes

- Have a treatment plan that documents treatment coordination and coordination with state agencies, if involved

Discharge Criteria

Tufts Health Plan Members may be discharged from acupuncture services if they:

- No longer meet medical necessity criteria and/or meet criteria for a different level of care (higher or lower).
- Meet individual treatment plan and goals
- Have a support system who agrees to follow through with patient care, and are able to be in a less-restrictive environment
- Have all appropriate community-based linkages in place
- Withdraw their consent for treatment, or their authorized representative withdraws consent
- 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

Excluded from this level of treatment are Tufts Health Plan Members who are actively suicidal or homicidal or who have a co-morbid psychiatric diagnosis that requires inpatient treatment.

CODES

The following CPT code(s) do not require prior authorization:

Table 1: CPT Codes

CPT Code	Description
H0014	Alcohol and/or drug services; ambulatory detoxification

REFERENCES

1. The American Psychiatric Press Textbook of Substance Abuse Treatment, Fourth Edition

APPROVAL HISTORY

July 1, 2002: Reviewed by the Utilization Management Committee

Subsequent endorsement date(s) and changes made:

- January 17, 2010: Documents reviewed and endorsed by BH practitioners
- February 12, 2010: Document reformatted, document history added
- February 17, 2012: Utilization Management Committee annual review, no changes made
- September 21, 2012: UMC Review, *Admission Criteria* changed to *Medical Necessity Criteria*, language was edited for clarity, *Continued Stay Criteria* changed to *Continued Treatment Criteria*, References edited
- February 20, 2013: Utilization Management Committee Review, "Network Health Choice" added to *Scope*
- July 19, 2013: Utilization Management Committee annual review, *Purpose* section added, *Discharge Criteria* 5th bullet changed from "Withdraw their consent for treatment or their parent or guardian withdraws consent" to "Withdraw their consent for treatment, or their authorized representative withdraws consent"
- November 8, 2013: Updated to include CarePlus product line
- July 2, 2014: Utilization Management Committee annual review, *Unify* added to *Scope*
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- December 9, 2015: Reviewed and approved by the Integrated Medical Policy Advisory Committee with no changes.
- November 9, 2016: Reviewed and approved by the Integrated Medical Policy Advisory Committee with no changes.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- May 10, 2017: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC). Changed from prior authorization required, to no prior authorization required.
- November 3, 2017: Reviewed and approved without changes by the Behavioral Health Practitioner Advisory Committee.
- November 8, 2017: Reviewed and approved by the Integrated Medical Policy Advisory Committee.

- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- October 16, 2019: Reviewed by IMPAC, 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.

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.