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

Effective: October 21, 2020

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: 857.304.6304
*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

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

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 Tufts Health 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 COVERAGE CRITERIA

Opioid Treatment Services Level of Care Criteria

Admission Criteria

Enrollees must meet all of the following:
- Have an active DSM-V Axis I diagnosis of opiate dependence
- Have evident and documented signs and symptoms of opioid withdrawal
- Meet all appropriate Drug Enforcement Agency (DEA) and Department of Public
- Health (DPH) regulations
- Have a sufficiently acute risk of relapse or continued opiate dependence and require a medication prophylaxis, regular counseling, and individualized urine monitoring

- 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:
- 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.
- 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

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

Practitioners must:
- Consider medication trials, as appropriate
- Ensure that Members receive 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, caregivers and family, as appropriate
- Attempt to discharge or move to a lower level of care

Discharge Criteria

Enrollees may be discharged from outpatient care if they:
- No longer meet admission criteria and/or meet criteria for a different level of care (higher or lower)
- Achieve treatment goals
- Have a support system that agrees to follow through with care, and are able to be in a less-restrictive environment
- Have all appropriate community-based linkages in place and functioning
- Withdraw consent for treatment, or a parent/guardian withdraws such consent
- 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

Members who have any of the following are excluded from the admission criteria above:
- Members with medical problems requiring hospitalization and/or illness that would interfere with methadone treatment
- Members who are experiencing acute withdrawal from opioids, sedative hypnotics, or stimulant drugs

CODES

The following HCPCS codes are associated with Opioid Treatment Services (Methadone Maintenance):

Table 1: HCPCS Codes

CPT/HCPCS 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

CPT/HCPCS Code	Description
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 HISTORY

July 1, 2002: Reviewed by the Utilization Management Committee

Subsequent endorsement date(s) and changes made:

- February 5, 2010: Documents reviewed and endorsed by BH practitioners
- February 12, 2010: Document reformatted, document history added
- February 7, 2011: Document and references validated and updated, additional criteria: Added, *"Exceptions for penal or chronic care may be admitted into methadone treatment within 14 days of release or within 6 months after release without documented evidence of physiological dependence provided that the individual was eligible for admission prior to incarceration";* Continued Stay: Added *"but not limited to";* Practitioners Must : Removed *"inappropriate"* and added *"appropriate ";* References: Added*, Network Health MassHealth Appendix H: Behavioral Health Exhibit 2: BH Clinical Criteria 2006, Network Health BH Level of Care Protocol and Procedural Guideline 2010, American Society of Addiction Medicine Patient Placement Criteria*
- February 11, 2011: Utilization Management Committee Annual Review
- December 16, 2011: Executive Policy Review and Update by Utilization Management Committee Chair and Network Health President, limited to Policy scope update to include new coverage product (MSP)
- February 17, 2012: Utilization Management Committee annual review
- September 21, 2012: Utilization Management Committee review, *References* edited
- February 20, 2013: Utilization Management Committee review, "Network Health Choice" added to *Scope*
- August 16, 2013: UMC Annual Review, *Purpose* added; "up to four sessions per week of" deleted from and "as clinically indicated" added to *Opioid Treatment Services*; "To receive narcotic treatment" deleted from *Admission criteria;* "interventions and other treatments" changed to "less intensive treatment interventions" in *Admission criteria,* bullet #3; "and/or recent relapse may be re-admitted, if there is a" added to *The following are addition narcotics treatment guidelines,* bullet #2; "Enrollee to continue getting this level of care, they must" changed to "To continue receiving this level of care, enrollees must" in *Continue-stay criteria;* "attempt or rule out medication trial, if appropriate" changed to "consider medication trials, as appropriate" in *Continue-stay criteria, Practitioner must,* bullet #1; "caregivers and family, as appropriate" added to *Continue-stay criteria, Practitioner must,* bullet #4; *Continue-stay criteria, Practitioner must,* bullet #5 added; fifth and sixth *Guideline References* added.
- November 8, 2013: Updated to include CarePlus product line
- 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 the following changes: Under the References section, MassHealth contract reference updated to the current version.
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- September 7, 2017: Administrative, table title updated
- 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 without changes
- October 10, 2018: Reviewed by Integrated Medical Policy Advisory Committee (IMPAC), renewed without changes
- October, 2018: Template and disclaimer updated
- August 14, 2019: Reviewed and approved by IMPAC with following changes: Addition of Methadone Maintenance to title, changed PA from "Yes" to "No", addition of language and link to the Out-of-Network Coverage at the In-Network Level of Benefits Medical Necessity Guideline (MNG)
- October 16, 2019: Reviewed by IMPAC, renewed without changes
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- November 4, 2020: Fax number for Unify updated

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.