Medical Necessity Guidelines: Recovery Coach

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

Overview

Recovery Coaches are individuals currently in recovery who have lived experience with addiction and/or co-occurring mental health disorders and have been trained to help their peers with a similar experience to gain hope, explore recovery and achieve life goals. Recovery Coaches are actively engaged in their own personal recovery and share real-world knowledge and experience with others who are on their own recovery path. Recovery Coaches share their recovery story and personal experiences in an effort to establish an equitable relationship and support Members in obtaining and maintaining recovery.

The primary responsibility of Recovery Coaches is to support the voices and choices of the Members they support, minimizing the power differentials as much as possible. The focus of the Recovery Coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Members to recovery community and serving as a personal guide and mentor. The Recovery Coach will work with the Member to develop a Wellness Plan that orients the activities of the Recovery Coach service.

Members can access Recovery Coaching services based on medical necessity and a referral by a medical or behavioral health provider, Community Partner (CP), or other care manager, that has contact with the Member and is able to identify the need for Recovery Coaching services. Recovery Coaches are employed by an organization that is able to provide supervision, an organizational culture that supports fidelity to the model and an environment that is conducive to the needs of Recovery Coaches and the Members they serve. The Recovery Coach service is based within a Licensed Behavioral Health Outpatient Clinic or Opioid Treatment Center and Recovery Coaches can be deployed to any setting.

CLINICAL COVERAGE CRITERIA

Admission Criteria

All of the following criteria are necessary for admission to this level of care:

1. The Member demonstrates symptomatology consistent with a DSM-5 diagnosis for a substance use disorder, AND at least one (1) of the following:
   a. is attempting to achieve and/or maintain recovery from substance use and/or co-occurring

disorders

b. could benefit from education about harm reduction and/or education about recovery and community resources
c. could benefit from support in increasing motivation and readiness to change
d. could benefit from peer support in establishing connections with the recovery community
e. could benefit from the structure of a Wellness Plan
f. is pregnant or up to 12-months postpartum, with or without custody

2. The Member is referred by a primary care provider for assistance with necessary medical follow-up.

Continued Stay Criteria

All of the following criteria are necessary for continuing in treatment at this level of care:

1. The Member is actively involved with the Recovery Coach and are making connection at least five times for every thirty days;
2. The Member is actively addressing components of the Wellness Plan and making adjustments as needed;
3. There is documented, active coordination of services with other behavioral health providers, the primary care provider, and other services and state agencies. If coordination is not successful, the reasons are documented, and efforts to coordinate services continue;
4. There is documented, active discharge planning starting with admission to Recovery Coach services; and
5. When medically necessary, the Member is supported in accessing appropriate psychopharmacological services.

Discharge Criteria

Any of the following criteria is sufficient for discharge from this level of care:

1. The Member no longer meets admission criteria;
2. Recovery Coach Wellness Plan goals and objectives have been met;
3. The Member or Member and parent and/or legal guardian is/are not utilizing or engaged in the RC service as demonstrated by fewer than five (5) contacts within a 30 day period (see performance specifications);
4. Consent for Recovery Coach services is withdrawn;
5. Support systems that allow the Member to be maintained in the community have been established.

Limitations

Exclusion Criteria

Any of the following criteria may be sufficient for exclusion from this level of care:

1. The Member is at acute risk to harm self or others, or sufficient impairment exists to require a more-intensive level of service beyond community-based intervention;
2. The Member has severe medical conditions or impairments that would prevent beneficial utilization of services;
3. The Member is receiving similar supportive services and does not require this level of care; **or**
4. The Member, and his/her parent/guardian/caregiver when applicable, does not consent to Recovery Coach services.

Codes

The following HCPCS code(s) are associated with these services:

Table 1: HCPCS Codes

HCPCS Code	Description
H2016-HM	Comprehensive community support services, per diem

Approval History

June 13, 2018: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), for effective date of July 1, 2018.

Subsequent endorsement date(s) and changes made:

- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated
- December 18, 2018: Effective January 1, 2019; this Medical Necessity Guideline is applicable to Unify
- 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
- December 2, 2020: Addition of HM modifier to CPT/HCPCS code

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.