Harvard Pilgrim Health Care | TUFTS Health Plan

Medical Necessity Guidelines: **Recovery Support Navigator**

Effective: January 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request.	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

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); 888-415-9055
☒ Tufts Health Together – MassHealth 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

☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-972-9409
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-972-9409
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-972-9409

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.

Notification is required for the first 90 days of service and must be submitted within 7 business days from the first date of service. Prior authorization must be obtained for coverage to continue beyond the first 90 days of service.

Overview

Recovery Support Navigator (RSN) services are staffed by paraprofessionals that provide care management and system navigation supports to Members with a diagnosis of substance use disorder and/or co-occurring mental health disorders. The purpose of Recovery Support Navigation services is to engage Members as they present in the treatment system and support them in accessing treatment services and community resources.

RSN services are appropriate for Members with substance use disorder and/or co-occurring disorders who are in need of additional support in remaining engaged in treatment; identifying and accessing treatment and recovery resources in the community including prescribers for addiction and psychiatric medications; and/or developing and implementing personal goals and objectives around treatment and recovery from addiction and/or co-occurring disorders.

The RSN explores treatment recovery options with the Member, helps clarify goals and strategies, provides education and resources, and assists Members in accessing treatment and community supports. RSN is not responsible for a Member's comprehensive care plan, or medical or clinical service delivery, but supports the Member in accessing those services and participates as part of the overall care team when appropriate.

The Recovery Support Navigator service is based within a Licensed Behavioral Health Outpatient Clinic, or an Opioid Treatment Center and Recovery Support Navigators can be deployed to any setting.

Clinical Guideline Coverage Criteria

Admission Criteria:

The Plan considers admission to this level of care* for recovery support navigator services as reasonable and medically necessary when **ALL** of the following criteria are met:

1. The Member demonstrates symptomatology consistent with a DSM-5 diagnosis for a substance use disorder, which requires and can reasonably be expected to respond to therapeutic intervention; **and**
2. The Member is at a transition point in his or her treatment and/or recovery and/or at risk for admission to 24-hour behavioral health inpatient/diversionary services, as evidenced by at least **ONE** of the following:
   a. Discharge from a 24-hour behavioral health inpatient/diversionary level of care within the past 180 days; **or**
   b. Multiple emergency service program (ESP) and/or emergency department (ED) encounters within the past 90 days; **or**
   c. Documented barriers to accessing and/or consistently utilizing essential medical and behavioral health services; **or**
   d. Initiating or changing an addiction pharmacotherapy or medication assisted treatment (MAT) regimen and/or changing MAT provider; **or**
   e. Release from incarceration within 90 days; **or**
   f. Loss of housing stability within 90 days; **or**
   g. Loss of employment within 90 days; **or**
   h. Loss of family support and connection within 90 days; **or**
   i. Currently pregnant or up to 12 months postpartum, with or without custody; **or**
   j. The Member is referred by a primary care practitioner for assistance with necessary medical follow-up.

*Exceptions may be made on a Member-by-Member basis.

Continued Stay Criteria:

The Plan considers continuing in treatment at this level of care for recovery support navigator services as reasonable and medically necessary when **ALL** of the following criteria are met:

1. Severity of illness and resulting impairment continue to warrant this level of care in order to maintain the Member in the community and continue progress toward RSN service plan goals and clinical treatment plan goals; **and**
2. The Member's treatment does not require a more-intensive level of care, and no less-intensive level of care would be appropriate or is available; **and**
3. After initial evaluation and stabilization, it is determined that the presenting symptomatology is indicative of a DSM-5 diagnosis (inclusive of psychosocial and contextual factors and disability, as applicable), which is amenable to continued services at this level of care. Conditions that would not be appropriate for continued RSN services are:
   a. Permanent cognitive dysfunction without acute DSM-5 diagnosis
   b. Medical illness requiring treatment in a medical setting
   c. Impairment with no reasonable expectation of progress toward RSN service plan goals at this level of care
   d. Chronic condition with no indication of need for ongoing services at this level of care to maintain stability and functioning; **and**
4. RSN services are rendered in a clinically appropriate manner and focused on the Member's behavioral and functional outcomes as described in the RSN service and discharge plans; **and**
5. RSN service planning is individualized and appropriate to the Member's age and changing condition, with realistic, specific, and attainable goals and objectives stated. RSN service planning includes family, support systems, social, educational, occupational, medical, and interpersonal assessments. This process should actively involve family, guardian, and/or other support systems unless contraindicated. Expected benefit from all planned services is documented. The RSN service plan is updated and implemented with consideration of all applicable and appropriate services and treatment modalities; **and**
6. All services and treatment are carefully structured to achieve optimum results in the most time-efficient manner possible consistent with sound clinical practice; **and**
7. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but goals of RSN services and clinical treatment services have not yet been achieved, or adjustments in the RSN service plan to address lack of progress are documented; **and**
8. The Member is actively participating in the RSN service plan and related treatment services, to the extent possible consistent with the Member's condition; **and**
9. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in RSN services.

When medically necessary, the Member has been referred to appropriate psychopharmacological services.

Discharge Criteria:

The Plan considers **ANY of** the following criteria to be sufficient for discharge from this level of care:

1. The Member no longer meets admission criteria or meets criteria for a less or more intensive level of care; **or**
2. RSN service plan goals and objectives have been substantially met, and/or a safe, continuing care program can be arranged and deployed at a less-intensive level of care; **or**
3. Consent for the RSN service is withdrawn. In addition, it has been determined that the Member, parent, and/or guardian has the capacity to make an informed decision, and the Member does not meet the criteria for a more intensive level of care; **or**
4. Support systems that allow the Member to be maintained in a less-restrictive treatment environment have been secured; **or**
5. The Member is not making progress toward RSN service plan goals, and there is no reasonable expectation of progress at this level of care, nor is it required to maintain the current level of functioning.

Note: Psychosocial, occupational, and cultural and linguistic factors, as detailed in the introduction, may change the risk assessment and are considered when making level of care decisions.

Limitations

The Plan considers recovery support navigator supports as not reasonable or medically necessary for **ANY** of the following:

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
4. The Member, and his/her parent/guardian/caregiver when applicable, does not consent to Recovery Support Navigator services.

Codes

The following code(s) are associated with this service

Table 1: CPT/HCPCS Codes

Code	Description
H2015-HF	Comprehensive community support services, per 15 minutes

References:

1. Massachusetts Behavioral Health Partnership. *Medical Necessity Criteria: BeHealthy Partnership.* Massachusetts Behavioral Health Partnership. Accessed September 19, 2025. https://providers.masspartnership.com/HNE/HNEMedNecessityCriteria.aspx

Approval And Revision History

October 21, 2020: Reviewed by IMPAC, renewed without changes.

Subsequent endorsement date(s) and changes made:

- October 29, 2020: Addition of HF modifier to CPT/HCPCS code.
- November 9, 2020: Fax number for Unify updated.
- September 15, 2021: Reviewed by IMPAC, renewed without changes.
- April 7, 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 updated 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
- December 18, 2024: Review by MPAC, administrative updates effective January 1, 2025
- August 20, 2025: Reviewed by MPAC, Updated notification and prior authorization language and addition of

timeframe language, to be effective December 1, 2025.
- November 19, 2025: Reviewed by MPAC for annual review, renewed without changes effective January 1, 2026
- December 2025: Administrative updates effective January 1, 2026
- December 8, 2025: Reviewed by UM Committee for annual review, renewed without changes effective January 1, 2026

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.