CHAPTER 8
SECTION 6

AUTHORIZATIONS

The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment can be made and of the procedures for requesting this authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed in paragraph 1.1., below, authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. The contractor shall emphasize the need for concerned persons to contact their health benefits advisor or the Health Care Finder for assistance. The contractor shall document authorization according to current contract requirements.

1.0. GENERAL

1.1. Authorization is required before benefits may be extended for all inpatient mental health care (including RTC, SUDRF, and PHP); adjunctive dental care; all care under the Program for Persons with Disabilities; and outpatient psychoanalysis and mental health care after eight visits. The contractor processes all requests for such authorization from beneficiaries residing within its jurisdiction. Because of the high risk that many services requiring special authorization may be denied, the contractor is required to offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction.

1.2. The contractor will issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian of a minor or incompetent, the provider, and to its claims processing staff. Notification may be made by letter, or on a form developed by the contractor. For the purposes of this manual, these forms and letters are all referred to as TRICARE authorization forms.

1.3. The contractor must maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. Authorization data or flags must be posted and/or set within five work days of issuance of the authorization. The contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

1.4. If a claim for the types of care in paragraph 1.1., above, is submitted with a copy of the authorization and a copy is not on file, the contractor *shall offer retrospective review. For care found to be medically necessary and appropriate based upon a retrospective review, the contractor shall reduce the provider's payment in accordance with TRICARE Reimbursement Manual, Chapter 1, Section 29, paragraph II.* If the contractor chooses to place added authorization/ preauthorization controls on network providers, it may do so. However, the TRICARE beneficiary must be "held harmless" in cases where the network provider fails to request authorization for care and the contractor denies payment, unless the beneficiary makes an

informed decision in writing to receive and pay for the care which has not been pre-authorized.

1.5. In those instances where a contractor offers voluntary authorization of services in addition to those listed above, such authorization must be available to and appealable by all beneficiaries, whether enrolled or not.

1.6. Clarification of authorization shall be made with the contractor benefit authorization unit, if necessary, If the data on the claim clearly does not match the authorization, and if the discrepancy cannot be resolved by contact with the authorizing unit, deny the claim.

2.0. PROGRAM FOR PERSONS WITH DISABILITIES

See the Policy Manual, Chapter 8, Section 1.18. A valid PFPWD authorization is sufficient evidence that the services and items authorized are necessary and appropriate. A claim for services or items which are allowable as a basic benefit that does not have a required PFPWD authorization attached, shall be processed as a basic program benefit claim. A claim for services or items which are only allowable as PFPWD benefits, which does not have a required PFPWD authorization attached, shall be developed for a retrospective PFPWD benefits authorization determination. Contractors shall maintain an automated authorization file or an automated system of flagging to ensure that PFPWD claims are processed consistent with the PFPWD benefit authorization. Each TRICARE contractor shall post the authorization or set the flags within five days of issuance or receipt of the authorization. When a request for PFPWD benefit authorization is received, TRICARE contractor personnel shall process the request within 21 calendar days. Within this time period, contractor personnel shall:

2.1. Verify that the copy of the beneficiary's PFPWD qualifying condition letter is current, or assist the beneficiary in applying for such letter;

2.2. Issue a benefit authorization letter for allowable PFPWD benefits or;

2.3. Issue a benefit authorization denial letter offering appeal rights, if applicable.

3.0. HOSPICE PROGRAMS

Network hospice providers must seek prior authorization from the Health Care Finder (HCF) for each election period (refer to TRICARE Reimbursement Manual, Chapter 11, Section 3 for detailed information on election process) unless the care is continuous throughout the subsequent election periods as long as the TRICARE beneficiary remains in the care of the hospice and does not revoke the election.

4.0. PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS

4.1. Before any claims for residential treatment center care can be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by TMA. When the contractor issues an RTC authorization, it shall flag its files to

preclude payment of any family or collateral therapy that is billed in the name of the residential treatment center patient. That cost is the responsibility of the residential treatment center, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the TMA-determined rates, family therapists may bill separately from the residential treatment center (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

4.2. If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. For network claims, the contractor may deny or develop in accordance with its agreements with network providers. For non-network claims, the contractor shall deny the claim.

4.3. For any claims submitted for inpatient care at other than the residential treatment center, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the residential treatment center has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the residential treatment center according to the provisions in Chapter 11.

5.0. GRANDFATHERED CUSTODIAL CARE CASES

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to each contractor with instructions to flag the file for those beneficiaries on the list who are within their region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor to notify the TMA, Beneficiary and Provider Services Directorate. Refer to 32 CFR 199.4.

6.0. FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See TRICARE Reimbursement Manual, Chapter 1, Section 29 and Chapter 3, Section 4.