CHAPTER 7
SECTION 3.2

LIMIT ON RESIDENTIAL TREATMENT CENTER (RTC) CARE

ISSUE DATE: March 13, 1992
AUTHORITY: 32 CFR 199.4(b)(8)
DoD Authorization Act, 1991, Public Law 101-510
DoD Appropriations Act, 1991, Public Law 101-511

I. BACKGROUND

In the National Defense Authorization Act for Fiscal Year 1991, Public Law 101-510 and the Defense Appropriations Act for 1991, Public Law 101-511, Congress firmly addressed the problem of spiraling costs for mental health services. Motivated by the desire to bring mental health care costs under control, Congress in both the Authorization and Appropriations Acts established certain benefit changes and management procedures. These statutes made two principal changes. First, they established new day limits for inpatient mental health services and secondly, they mandated prior authorization for all nonemergency inpatient mental health admissions, with required certification of emergency admissions within 72 hours.

II. POLICY

Effective October 1, 1991, no funds shall be used to pay for residential treatment center (RTC) care in excess of 150 days in a fiscal year or 150 days in an admission (hereinafter referred to as the 150 day limit). Preadmission authorization is required for all care in a residential treatment center. Admission to an RTC is considered elective and not of an emergency nature. For admission to an RTC, a psychiatrist or clinical psychologist shall recommend admission and direct the treatment plan.

III. POLICY CONSIDERATIONS

Congress established the specific day limits and a waiver authority. In order to give the day limits some meaningful effect, we must consider them presumptive limits, subject to waiver in special cases.

A. The day limit is generally based on a fiscal year, except that if the applicable number of days is reached during a single admission, the day limit waiver will also be required. The day limits trigger the waiver review process.

B. Payment Responsibility

1. Providers must adhere to TRICARE rules which disallow billing the patient or the patient's family for excluded services, unless the patient, or some other person with legal authority to sign in behalf of the patient, signs a written statement that:

a. The patient specifically understands that the services would likely not be covered; and

b. The patient agrees to pay for the services.

2. If a request for waiver is filed and the waiver is not granted by the Executive Director TMA, or a designee, benefits will only be allowed for the period of care authorized by the Mental Health Review Contractor or appropriate managed care contractor.

IV. EXCEPTIONS

A. This limit does not apply to:

1. Any services provided under the Program for Persons with Disabilities.

2. Any services provided in an acute inpatient mental health facility.

3. Any services provided as partial hospitalization (less than 24-hour-a-day care), if such services are covered by TRICARE.

B. Waiver of Limits. There is a statutory presumption against the appropriateness of RTC services in excess of the 150 day limit. However, the contractor may in special cases, after considering the opinion of the peer review designated by the Director (involving a health professional who is not a federal employee) confirming that applicable criteria have been met, waive the RTC benefit limit and authorize payment for care beyond that limit.

1. Waiver of the 150 day limit may be granted if determined to be medically or psychologically necessary. In determining the medical or psychological necessity of services and supplies provided by RTCs, the evaluation conducted by the contractor shall consider the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. The criteria for waiver of the 150 day limit are listed in Chapter 7, Section 3.4. In applying those criteria to the context of waiver request reviews, special emphasis is placed on assuring that the record documents that:

a. Active treatment has taken place for the past 150 days and substantial progress has been made according to the plan of treatment.

b. The progress made is insufficient, due to the complexity of the illness, for the patient to be discharged to a less intensive level of care.

c. Specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days of RTC care.

d. The waiver request includes specific time frames and a specific plan of treatment which will lead to discharge.

2. Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit.

3. It is the responsibility of the patient's attending clinician to establish, through actual documentation from the medical record and other sources, that the conditions for waiver exist.

C. For purposes of counting day limits, a move from one facility to another facility can be considered a transfer when documentation establishes that coordination for the move existed between two like facilities for the purpose of ensuring continued treatment of the condition requiring the original admission. Under these circumstances, the admission to a new facility would be considered a continuous uninterrupted episode of care. If the documentation does not establish that coordination for the move existed between the two facilities, then the intent to transfer cannot be established and the move should be considered a discharge.

V. EFFECTIVE DATE

RTC services provided on and after October 1, 1991. Patients in an RTC prior to October 1, 1991, are subject to the limitation of 150 days; however, the count does not begin until October 1, 1991.

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