Chapter 1 Section 7.1

Special Authorization Requirements

Issue Date: August 4, 1988
Authority: 32 CFR 199.4(a)(12), 32 CFR 199.5(h)(3) and 32 CFR 199.15(b)(4)

1.0 POLICY

Unless otherwise specifically excepted, the adjudication of the following types of care is subject to the following authorization requirements:

1.1 Adjunctive dental care must be preauthorized.

1.2 Dental anesthesia and institutional benefit must be preauthorized. See Chapter 8, Section 13.2, paragraph 2.5.

1.3 Extended Care Health Option (ECHO) benefits must be authorized in accordance with Chapter 9, Section 4.1.

1.4 Effective October 1, 1991, preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be cost-shared (includes Residential Treatment Center (RTC) care and alcoholism detoxification and rehabilitation). Effective September 29, 1993, preadmission and continued stay authorization is also required for all care in a Partial Hospitalization Program (PHP).

1.5 Effective November 18, 1991, psychoanalysis must be preauthorized.

1.6 The Director, TRICARE Management Activity (TMA), or designee, may require preauthorization of admission to inpatient facilities.

1.7 Organ and stem cell transplants are required to be preauthorized. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in this TRICARE Policy Manual (TPM), or until the approved transplant occurs.

1.8 Infusion therapy delivered in the home must be preauthorized in accordance with Chapter 8, Section 20.1.

1.9 Effective for dates of service **June 1, 2010**, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. See the TRICARE Operations

Manual (TOM), Chapter 7, Section 2 and the TRICARE Reimbursement Manual (TRM), Chapter 8, Section 2.

1.10 Each TRICARE Regional Managed Care Support Contractor (MCSC) may require additional care authorizations not identified in this section. Such authorization requirements may differ between regions. Beneficiaries and providers are responsible for contacting their contractor for a listing of additional regional authorization requirements.

Note: When a beneficiary has "other insurance" that provides primary coverage, preauthorization requirements in paragraph 1.10. will not apply. Any medically necessary reviews the MCS contractor believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis. The conditions for applying this exception are the same as applied to the Non-Availability Statement (NAS) exception in Section 6.1, paragraph 3.1.

1.11 Provider payments are reduced for the failure to comply with the preauthorization requirements for certain types of care. See the TRM, Chapter 1, Section 28.

2.0 EXCEPTIONS

2.1 For dual eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

2.2 The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their Primary Care Manager (PCM) to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. Point Of Service (POS) cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

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