Chapter 7 Section 3.5

Preauthorization Requirements For Substance Use Disorder Detoxification And Rehabilitation

Issue Date: March 13, 1992
Authority: 32 CFR 199.4(b)(6)(iii) and 10 USC 1079(a)

1.0 BACKGROUND

In the National Defense Authorization Act for Fiscal Year 1991 (NDAA FY 1991), Public Law 101-510 and the Defense Appropriations Act for 1991, Public Law 101-511, Congress addressed the problem of spiraling costs for mental health services under TRICARE. 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.

2.0 POLICY

Effective October 1, 1991, preadmission and continued stay authorization is required before services for substance use disorders may be cost-shared. Preadmission and continued stay authorization is required for both detoxification and rehabilitation services. To comply with the statutory requirements and to avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. All admissions for rehabilitation are elective and must be certified as medically/psychologically necessary prior to admission. The admission criteria shall not be considered satisfied unless the patient has been personally evaluated by a physician or other authorized health care professional with admitting privileges to the facility to which the patient is being admitted prior to the admission.

3.0 POLICY CONSIDERATIONS

3.1 Treatment of Mental Disorders

In order to qualify for mental health benefits, the patient must be diagnosed by a licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) or a mental health diagnosis in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) for services provided prior to International Classification of Diseases, 10th Revision (ICD-10) implementation or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for services provided on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**. Benefits are limited for certain mental disorders, such as specific developmental disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder", or **V** codes. In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a

result of a diagnosed mental disorder, be experiencing both physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational or social roles. It is generally the degree to which the patient's ability to function is impaired that determines the level of care (if any) required to treat the patient's condition.

3.2 Admissions occurring on or after October 1, 1991, to all facilities (includes Diagnosis Related Group (DRG) and non-DRG facilities).

3.2.1 Detoxification. Stays for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit which went into effect October 1, 1991, limiting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (age 18 and under). In determining the medical or psychological necessity of detoxification and rehabilitation for substance use disorder, the evaluation conducted by the contractor shall consider the appropriate level of care for the patient and the intensity of services required by the patient. Emergency and inpatient hospital services are covered when medically necessary for the active medical stabilization, and for treatment of medical complications of substance use disorder. Authorization prior to admission is not required in the case of an emergency requiring an inpatient acute level of care, but authorization for a continuation of services must be obtained promptly. Admissions resulting from a bona fide emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the contractor within 72 hours of the admission. Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required. Stays for detoxification in a substance use disorder facility are limited to seven days unless the limit is waived by the contractor and must be provided under general medical supervision.

3.2.2 Rehabilitative care. The patient's condition must be such that rehabilitation for substance use disorder must be provided in a hospital or in an organized inpatient substance use disorder treatment program. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of stays classified in DRG 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to the DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care unless the limit is waived by the contractor. Days of rehabilitation must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (aged 18 and under). The concept of an emergency admission does not apply to rehabilitative care.

3.2.3 Waiver of Benefit Limits. The specific benefit limits set forth in this chapter may be waived by the contractor in special cases based on a determination that all of the following are met:

3.2.3.1 Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

3.2.3.2 Further progress has been delayed due to the complexity of the illness.

3.2.3.3 Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

3.2.3.4 The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

3.2.4 The request for preauthorization must be received by the contractor prior to the planned admission. In general, the decision regarding preauthorization shall be made within one business day of receipt of a request for preauthorization, and shall be followed with written confirmation. In the case of an authorization issued after an admission resulting from approval of a request made prior to the admission, the effective date of the certification shall be the date of the receipt of the request. If the request on which the approved authorization is based was made after the admission (and the case was not an emergency admission), the effective date of the authorization shall still be the date of receipt of the request. The contractor may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

3.2.5 Preadmission authorization is required even when the beneficiary has other health insurance because the statutory requirement is applicable to every case in which payment is sought, regardless of whether it is first payer or second payer basis.

3.3 Payment Responsibility

3.3.1 Any inpatient mental health care obtained without requesting preadmission authorization or rendered in excess of the 30/45 day limit (or beyond the DRG long-stay outlier) without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the responsibility of the patient or the patient's family until:

3.3.1.1 Receipt of written notification by a contractor that the services are not authorized; or

3.3.1.2 Signing of a written statement from the provider which specifically identifies the services which will not be reimbursed. The beneficiary must agree, in writing, to personally pay for the non-reimbursable services. General statements, such as those signed at admission, do not qualify.

3.3.2 If a request for waiver is filed and the waiver is not granted by the contractor benefits will only be allowed for the period of care authorized.

3.4 Concurrent Review

Concurrent review of the necessity for continued stay will be conducted. For care provided under the DRG-based payment system, concurrent review will be conducted only when the care falls under the DRG long-stay outlier. The criteria for concurrent review shall be those set forth in paragraph 3.2. In applying those criteria in the context of concurrent review, special emphasis is placed on evaluating the progress being made in the active clinical treatment being provided and on developing/refining appropriate discharge plans. In general, the decision regarding concurrent review shall be made within one business day of the review, and shall be followed with written confirmation.

3.5 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 (EOC). 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.

4.0 EXCEPTION

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.

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