

Chapter 7

Section 3.1

Acute Hospital Psychiatric Care

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1.0 BACKGROUND

1.1 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 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.

1.2 The NDAA FY 2015, Section 703, signed into law on December 19, 2014, removed TRICARE statutory limitations on inpatient mental health services (30 days for adults, 45 days for children) and Residential Treatment Center (RTC) care for children (150 days), including the corresponding waiver provisions. The removal of inpatient days for mental health services, which placed quantitative limitations on mental health treatment that do not exist for medical or surgical care, is consistent with principles of mental health parity. Further, the Department believes these changes will reduce stigma and enhance access to care, which continue to be high priorities within the Department of Defense (DoD). As a result, inpatient mental health services, regardless of length/quantity, may be covered as long as the care is considered medically or psychologically necessary and appropriate.

2.0 POLICY

2.1 Effective December 19, 2014, day limits in any fiscal year are removed for TRICARE beneficiaries of all ages for the provision of acute inpatient mental health services. Criteria for medical and psychological necessity continue to apply for inpatient mental health services and take into account the level, intensity, and availability of the care needs of the patient.

2.2 Preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be provided and cost-shared. Prompt continued stay authorization is required after emergency admissions. To avoid denial, requests for preadmission authorization on weekends and holidays are discouraged. 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

Medical and psychological necessity will determine the Length-of-Stay (LOS) for treatment in an acute inpatient mental health care facility. The contractor shall use established criteria for preadmission, concurrent review, and continued stay decisions. If a case involves both Substance Use Disorder (SUD) and other **Diagnostic and Statistical Manual of Mental Disorders** (DSM) diagnoses, the 21-day limit would apply if the patient was admitted to a Diagnosis-Related Group (DRG) exempt SUD rehabilitation unit.

3.1 Treatment of Mental Disorders

In order to qualify for mental health benefits, the patient must be diagnosed by an authorized licensed, qualified mental health professional to be suffering from a mental disorder, according to the criteria listed in the current edition of the DSM. Benefits are limited for certain mental disorders, such as specific learning disorders. No benefits are payable for "Conditions Not Attributable to a Mental Disorder", or International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) **V** codes, or International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) **Z** codes. **Co-occurring mental and Substance Use Disorders (SUDs) are common and assessment should proceed as soon as it is possible to distinguish the substance related symptoms from other independent conditions.** 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 Criteria for Determining Medical or Psychological Necessity

In determining the medical or psychological necessity of acute inpatient mental health services, the evaluation conducted by the Director, Defense Health Agency (DHA) (or designee) 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 purpose of such acute inpatient care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate only if the patient requires services of an intensity and nature that are generally recognized as being effectively and safely provided only in an acute inpatient hospital setting. Acute inpatient care shall not be considered necessary unless the patient:

3.2.1 Needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or

3.2.2 Requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:

3.2.2.1 Patient poses a serious risk of harm to self and/or others.

3.2.2.2 Patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects.

3.2.2.3 Patient has acute disturbances of mood, behavior, or thinking.

3.3 Emergency Admissions

Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, the following criteria, in addition to those in [paragraph 3.2](#) must be met:

3.3.1 The patient must be at immediate risk of serious harm to self and or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority); and

3.3.2 The patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

3.4 Preauthorization Requirements

All non-emergency admissions to an acute inpatient hospital level of care must be authorized prior to the admission. The criteria for preauthorization shall be those set forth in [paragraph 3.2](#). In applying those criteria in the context of preauthorization review, special emphasis is placed on the development of a specific individualized treatment plan, consistent with those criteria and reasonably expected to be effective, for that individual patient.

3.4.1 The request for preauthorization must be received by the reviewer designated by the Director, DHA, or designee, 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 authorization 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. If the care is found not medically necessary, however, and is not approved, the provider is liable for the services but has the right to appeal the "not medically necessary" determination. Only non-network providers may appeal as network providers are never appropriate appealing parties.

3.4.2 Authorization prior to admission is not required in the case of a psychiatric 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 psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the Director, DHA or a designee, within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

3.4.3 Preadmission authorization is required even when the beneficiary has Other Health Insurance (OHI) 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. When a beneficiary has OHI that provides coverage, an exception to prior authorization requirements will apply as provided in [Chapter 1, Section 6.1, paragraph 1.11](#). For beneficiaries with Medicare, preauthorization requirements apply

when TRICARE is primary payer. As a secondary payer, TRICARE will rely on, and not replicate, Medicare's determination of medical or psychological necessity and appropriateness in all circumstances where Medicare is the primary payer. When the beneficiary has OHI that is primary to TRICARE, all double coverage provisions in the TRICARE Reimbursement Manual (TRM), [Chapter 4](#), shall apply. In the event that TRICARE is the primary payer for these services, and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

3.5 Payment Responsibility

Any inpatient mental health care obtained without requesting preadmission authorization or rendered 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:

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

3.5.2 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.

3.5.3 See TRM, [Chapter 1, Section 28](#) and [Chapter 3, Section 4](#) for policies on payment reductions.

3.6 Concurrent Review

Concurrent review of the necessity for continued stay will be conducted. 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.

4.0 EFFECTIVE DATES

4.1 Inpatient services provided on or after October 1, 1991.

4.2 Removal of day limits in any fiscal year for TRICARE beneficiaries of all ages for the provision of acute inpatient mental health services on or after December 19, 2014.

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