Chapter 7 Section 3.3

Inpatient/Residential Substance Use Disorder (SUD) Detoxification And Rehabilitation

Issue Date: March 13, 1992
Authority: 32 CFR 199.4(b)(6)(iii), (b)(8), and 32 CFR 199.6(b)(4)(xiv)
Revision: C-13, November 15, 2017

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.

1.3 With the implementation of the Final Rule, Federal Register, Volume 81, No. 171, September 2, 2016, TRICARE Mental Health and SUD Treatment, TRICARE eliminated all remaining regulatory quantitative limits on mental health care, consistent with mental health parity, to include the 21-day limit for SUD rehabilitation.

2.0 POLICY

Preadmission and continued stay authorization is required before nonemergency inpatient and residential services for SUDs 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 authorized 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 diagnoses made before the mandated date, as directed by Health and Human Services (HHS), for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) implementation, after which the ICD-10-CM diagnoses must be used. 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 ICD-9-CM **V** codes or ICD-10-CM **Z** codes. Co-occurring mental and 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

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. In determining the medical or psychological necessity of detoxification and rehabilitation for SUD, the evaluation conducted by the Director, Defense Health Agency (DHA), or designee, 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 SUD as evaluated by a physician or other authorized health care professional. 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 shall be reported within 24 hours of the admission or the next business day after the admission to the contractor. 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. All inpatient/residential Substance Use Disorder Rehabilitation Facility (SUDRF) care, including non-emergent detoxification services provided in a SUDRF as a part of the Episode Of Care (EOC), must be preauthorized.

3.2.2 Rehabilitative care: The patient's condition must be such that rehabilitation for SUD must be provided in a hospital or a freestanding inpatient SUD treatment program. Rehabilitation stays are

covered if preauthorized as medically/psychologically necessary. The concept of an emergency admission does not apply to rehabilitative care.

3.3 Preauthorization Requirements

All non-emergency admissions to an inpatient/residential SUD detoxification and rehabilitation program 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.

3.3.1 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 or psychologically necessary, and is not approved, the provider is liable for the services, but has the right to appeal the "not medically or psychologically necessary" determination. Only non-network participating providers may appeal as network providers are never appropriate appealing parties.

3.3.2 When the beneficiary has Other Health Insurance (OHI) that provides coverage, exception to the preauthorization requirements will apply as provided in Chapter 1, Section 6.1, paragraph 1.12. When the contractor is acting as a secondary payer, any medically or psychologically necessary reviews shall be performed on a retrospective basis. For beneficiaries with Medicare, preauthorization requirements apply when TRICARE is the 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 primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

3.4 Payment Responsibility

Any inpatient mental health care obtained for inpatient/rehabilitation SUD detoxification and rehabilitation without requesting preadmission authorization, without following concurrent review requirements, in which the services are determined excluded by reason of being not medically or psychologically necessary, is not the responsibility of the patient or the patient's family until:

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

3.4.2 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.

3.4.3 See the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 28 and Chapter 3, Section 4 for policies on payment reductions.

3.5 Concurrent Review

Concurrent review of the necessity for continued stay will be conducted no less frequently than every 30 days. 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 Removal of day limits in any fiscal year for TRICARE beneficiaries of all ages for the provision of inpatient/residential SUD services on or after December 19, 2014.

4.2 Removal of quantitative limits on mental health and SUD care, October 3, 2016.

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