

SUBSTANCE USE DISORDERS

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I. DESCRIPTION

Complication of alcohol and drug abuse or dependency and detoxification.

II. POLICY

TRICARE may cost-share specific coverage for the treatment of substance use disorders including detoxification, rehabilitation, and outpatient care provided in authorized substance use disorder rehabilitation facilities in accordance with the "Policy Considerations" below.

III. POLICY CONSIDERATIONS

A. Emergency and inpatient hospital services.

1. Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance abuse withdrawal (detoxification), for stabilization, and for treatment of medical complications of substance use disorders.

2. 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.

3. Stays provided for substance use disorder rehabilitation in a hospital-based facility are covered when provided as outlined in "Policy Considerations" [paragraph III.B.](#)

4. Inpatient hospital services are subject to the provisions regarding the limit on inpatient mental health services. (See [Chapter 1, Section 12.1B](#)).

5. Inpatient hospital services are subject to the statutory requirement for preauthorization.

B. Authorized substance use disorder treatment.

1. Only those services provided by TRICARE authorized institutional providers are covered. Such a provider must be either an authorized hospital, or an organized substance use disorder treatment program in an authorized freestanding or hospital-based substance use disorder rehabilitation facility.

2. A qualified mental health provider (physicians, clinical psychologists, clinical social workers, and psychiatric nurse specialists) shall prescribe the particular level of treatment.

3. Each TRICARE beneficiary is entitled to three substance use disorder treatment benefit periods in his or her lifetime. A waiver may be extended in accordance with the criteria in [paragraph III.E.](#) below.

a. A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period.

b. Emergency and inpatient hospital services as described under [paragraph III.A.1.](#), do not constitute substance abuse treatment for the purposes of establishing the beginning of a benefit period.

c. Unused benefits cannot be carried over to subsequent benefit periods.

C. Covered services.

1. Rehabilitative care in an authorized hospital or substance use disorder facility, whether freestanding or hospital-based, is covered on either a residential or partial care (day, evening or weekend) basis.

a. Residential Care is subject to the following:

(1) Care must be preauthorized.

(2) Coverage during a single benefit period is limited to no more than one inpatient stay (exclusive of stays classified in DRG 433) in hospitals subject to TRICARE/CHAMPUS DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitation care, unless the limit is waived in accordance with the criteria in [paragraph III.E.](#) below.

(3) If the patient is medically in need of chemical detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to rehabilitative care, but in a DRG-exempt facility detoxification services are limited to 7 days, unless the limit is waived in accordance with the criteria in [paragraph III.E.](#) below.

(4) The medical and psychological necessity of the detoxification must be documented. Any detoxification services provided in the substance use disorder rehabilitation facility must be under general medical supervision.

b. Partial care is subject to the following.

- (1) Care must be preauthorized
- (2) Coverage during a single benefit period is limited to 21 days unless the limit is waived in accordance with the criteria in [paragraph III.E](#).
- (3) Refer to [Chapter 13, Section 6.8](#) for reimbursement of partial care.

NOTE: The beneficiary may have either 21 days of rehabilitation on a residential (inpatient) basis or 21 days of rehabilitation in a partial hospital setting, or a combination of both, as long as the 21-day limit for the total rehabilitation period is not exceeded.

2. Outpatient care is subject to the following:

- a. Outpatient care (substance use disorder) must be provided by an approved substance use disorder rehabilitation facility, whether freestanding or hospital-based. Certified addiction rehabilitation counselors or certified alcohol counselors employed by the SUDRF may provide the care.
- b. The SUDRF must bill for the services using TRICARE code 90834. Payment is made based on billed charges but is not to exceed the allowable amount for CPT 90853.
- c. Coverage is up to 60 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph III.E](#) below.
- d. Outpatient care is covered in a group setting only. Individual outpatient care will be denied. **For patients with a primary diagnosis of a mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder, see [Chapter 1, Section 12.7](#).**

3. Family Therapy.

- a. Family therapy provided on an outpatient basis by an approved substance use disorder rehabilitation facility, whether freestanding or hospital-based, is covered beginning with the completion of the patient's rehabilitative care as outlined in "Policy Considerations," [paragraph III.C.1](#). The family therapy is covered for up to 15 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph III.E](#) below. (See [Chapter 13, Section 6.8](#).) Services provided on an outpatient basis will be reimbursed under the appropriate CMAC for the procedure code(s) billed.
- b. Family therapy must be provided by a qualified mental health provider (psychiatrists or other physicians, clinical psychologists, certified psychiatric nurse specialists or clinical social workers; and certified marriage and family therapists, pastoral, and mental health counselors, under a physician's supervision).

D. Coverage limitations.

1. Detoxification. Admissions to all facilities (includes DRG and non-DRG facilities) for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit, 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).

2. Rehabilitation. Rehabilitation stays are subject to a limit of 3 benefit periods in a lifetime unless this limit is waived by the **managed care contractor**. Preadmission and continued stay authorization is required for substance use disorder detoxification and rehabilitation. (See [Chapter 1, Section 12.1F](#), for details on preauthorization requirements.) Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. 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.

E. Waiver of benefit limits. The specific benefit limits set forth in this section may be waived by the **managed care contractor** in special cases based on a determination that all of the following criteria are met:

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.
2. Further progress has been delayed due to the complexity of the illness.
3. Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.
4. The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

F. Payment responsibility. Providers may not hold patients liable for payment for services for which TRICARE payment is disallowed due to the provider's failure to follow established procedures for preadmission and continued stay authorization. With respect to such services, providers may not seek payment from the patient or the patient's family, unless the patient has agreed to personally pay for the services knowing that TRICARE payment would not be made. Any such effort to seek payment is a basis for termination of the provider's authorized status (see [Chapter 13, Section 16.1](#)).

G. Related Policy Manual material.

1. [Chapter 1, Section 12.1F](#), Preauthorization Requirements For Substance Use Disorders Detoxification And Rehabilitation.
2. [Chapter 13, Section 6.1D](#), Hospital Reimbursement - TRICARE/CHAMPUS DRG-Based Payment System.
3. [Chapter 13, Section 6.5](#), Hospital Reimbursement - TRICARE/CHAMPUS Inpatient Mental Health Per Diem Payment System.
4. [Chapter 13, Section 6.8](#), Substance Use Disorder Rehabilitation Facilities Reimbursement.

5. **Chapter 11, Section 11.7, Substance Use Disorder Rehabilitation Facilities Certification Process.**

H. Antabuse® in the treatment of alcoholism is cost-shared.

I. Confidentiality. Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended, (42 U.S.C. 290dd-3), which governs the release of medical and other information from the records of patients undergoing treatment of substance use disorder. If the patient refuses to authorize the release of medical records which are, in the opinion of the Director, TRICARE, or a designee, necessary to determine benefits on a claim for treatment of substance use disorder the claim will be denied.

IV. EXCEPTIONS

A. Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol or other drugs (except Antabuse®) as negative reinforcement is not covered, even if recommended by a physician. All professional and institutional charges associated with a rehabilitation treatment program that uses aversion therapy must also be denied.

B. Domiciliary settings. Domiciliary facilities, generally referred to as halfway or quarterway houses, are not authorized providers. Charges for services provided by these facilities are not covered.

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