

Preauthorization Requirements For Substance Use Disorder (SUD) Detoxification And Rehabilitation

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Authority: 32 CFR 199.4(b)(6)(iii), (e)(4)(ii)(A), and (e)(4)(v), and 10 USC 1079(a)

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 The NDAA FY 2015 removed statutory day limits for inpatient mental health services and by extension the days of detoxification previously counted toward statutory day limits; however, the 21-day limit for SUD rehabilitation remains in place. Regulatory requirements for no more than seven days detoxification and 21 days residential treatment during a single benefit period have not changed; however, these day limits no longer count toward a statutory limitation of 30-days inpatient mental health services. The practical implication is that a beneficiary could have one or more acute inpatient psychiatric admissions during a single benefit period and one or more detoxification and rehabilitation admissions in the same year; even though the total number of inpatient days would exceed 30 days. Requirements have not changed for concurrent review of the necessity for continued stay and exceptions.

2.0 POLICY

Preadmission and continued stay authorization is required before services for SUDs may be

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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 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**. 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. In determining the medical or psychological necessity of detoxification and rehabilitation for **SUD**, 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 **SUD**. 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. Stays for detoxification in a **SUD** 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 **SUD** must be provided in a hospital or in an organized inpatient **SUD** 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

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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. 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 When the beneficiary has Other Health Insurance (OHI) that provides coverage, exception to the preauthorization requirements will apply as provided in Chapter 1, Section 7.1, paragraph 1.10. When the contractor is acting as a secondary payer, any medical necessity reviews shall be performed on a retrospective basis.

3.3 Payment Responsibility

3.3.1 Any inpatient mental health care obtained for 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 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.

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3.3.2 If a request for waiver is filed for Length-of-Stay (LOS) 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.

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. 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.

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