



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 90
6010.54-M
SEPTEMBER 29, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

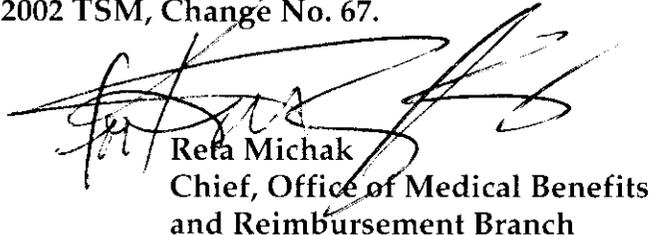
CHANGE TITLE: MAY 2007 CONSOLIDATED CHANGE

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change consists primarily of administrative changes and clarifications. Also included are the following: removal of requirement to send annual renewal letters to Active Duty Service Members (ADSMs) without dependents; revises DD2642 claim form; adds language regarding NASA Astronauts; extends Noble Eagle/Enduring Freedom Reserve Family Demonstration to 2009; excludes the use of the sponsor's Social Security Number (SSN) on the Monthly Health Insurance Portability and Accountability Act (HIPAA) Complaint Report; and clarifies preauthorized requirements for TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) claims.

EFFECTIVE AND IMPLEMENTATION DATE: October 1, 2008.

This change is made in conjunction with Aug 2002 TOM, Change No. 72, Aug 2002 TRM, Change No. 83, and Aug 2002 TSM, Change No. 67.


Refa Michak
Chief, Office of Medical Benefits
and Reimbursement Branch

ATTACHMENT(S): 6 PAGE(S)
DISTRIBUTION: 6010.54-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 90
6010.54-M
SEPTEMBER 29, 2008

REMOVE PAGE(S)

CHAPTER 1

Section 7.1, pages 1 and 2

CHAPTER 7

Section 3.5, pages 3 and 4

Section 3.6, pages 3 and 4

INSERT PAGE(S)

Section 7.1, pages 1 and 2

Section 3.5, pages 3 and 4

Section 3.6, pages 3 and 4

SUMMARY OF CHANGES

CHAPTER 1

1. Section 7.1, page 2. In paragraph II., reworded paragraph to clarify preauthorization requirements for TDEFIC claims.

CHAPTER 7

2. Section 3.5, page 4. In paragraph IV., reworded paragraph to clarify preauthorization requirements for TDEFIC claims.
3. Section 3.6, page 4. In paragraph VI., added language to clarify preauthorization requirements for TDEFIC claims.

SPECIAL AUTHORIZATION REQUIREMENTS

ISSUE DATE: August 4, 1988

AUTHORITY: [32 CFR 199.4\(a\)\(12\)](#), [32 CFR 199.5\(h\)\(3\)](#) and [32 CFR 199.15\(b\)\(4\)](#)

I. POLICY

Unless otherwise specifically excepted, the adjudication of the following types of care is subject to the following authorization requirements:

- A. Adjunctive dental care must be preauthorized.
- B. **Dental anesthesia and institutional benefit must be preauthorized. See Chapter 8, Section 13.2, paragraph II.E.**
- C. Extended Care Health Option (ECHO) benefits must be authorized in accordance with [Chapter 9, Section 4.1](#).
- D. Effective October 1, 1991, preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be cost-shared (includes Residential Treatment Center care and alcoholism detoxification and rehabilitation). Effective September 29, 1993, preadmission and continued stay authorization is also required for all care in a partial hospitalization program.
- E. Effective November 18, 1991, psychoanalysis must be preauthorized.
- F. The Executive Director, TMA, or designee, may require preauthorization of admission to inpatient facilities.
- G. Organ and stem cell transplants are required to be preauthorized. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in this Policy Manual, or until the approved transplant occurs.
- H. Each TRICARE Regional Managed Care Support (MCS) contractor may require additional care authorizations not identified in this section. Such authorization requirements may differ between regions. Beneficiaries and providers are responsible for contacting their contractor for a listing of additional regional authorization requirements.

NOTE: When a beneficiary has "other insurance" that provides primary coverage, preauthorization requirements in [paragraph I.H.](#) will not apply. Any medically necessary

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 1, SECTION 7.1

SPECIAL AUTHORIZATION REQUIREMENTS

reviews the MCS contractor believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis. The conditions for applying this exception are the same as applied to the NAS exception in [Chapter 1, Section 6.1, paragraph III.A.](#)

I. Provider payments are reduced for the failure to comply with the preauthorization requirements for certain types of care. See the TRICARE Reimbursement Manual, [Chapter 1, Section 28.](#)

II. 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.

- END -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.5

PREAUTHORIZATION REQUIREMENTS FOR SUBSTANCE USE DISORDER DETOXIFICATION AND REHABILITATION

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

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

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.

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.

C. Payment Responsibility

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:

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

b. 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.

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.

D. 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 III.B](#). 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

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.5

PREAUTHORIZATION REQUIREMENTS FOR SUBSTANCE USE DISORDER DETOXIFICATION AND REHABILITATION

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.

E. 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. 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.

IV. 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.

- END -

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.6

PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS - PREAUTHORIZATION AND DAY LIMITS

1. Any care in a psychiatric partial hospitalization program obtained without requesting preadmission authorization or rendered in excess of the 60-day limit without following concurrent review requirements, in which the services are determined excluded by reason of being not medically necessary, is not the financial responsibility of the patient or the patient's family until:

a. Receipt of written notification from a contractor that the services are not authorized; or

b. 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.

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

B. 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. 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.

V. EXCEPTIONS

Waiver of the 60-day psychiatric partial hospitalization limit. The purpose of partial hospitalization is to provide an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and as a transition from an inpatient program when medically necessary to avoid a serious deterioration in functioning within the context of a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. There is a regulatory presumption against the appropriateness of partial hospitalization in excess of 60 days. However, a waiver may be authorized through the contractor and payment allowed for care beyond the 60-day limit in certain circumstances.

A. The criteria for waiver are set forth in POLICY, above. In applying these criteria in the context of a waiver request review, special emphasis is placed on determining whether additional days of partial hospitalization are medically/psychologically necessary to complete essential elements of the treatment plan prior to discharge. Consideration is also given in cases in which a patient exhibits well-documented new symptoms or maladaptive behaviors which have appeared in the partial hospitalization setting requiring significant revisions to the treatment plan.

B. The clinician responsible for the patient's care is responsible for documenting the need for additional days and must establish an estimated length of stay beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment,

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 7, SECTION 3.6

PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAMS - PREAUTHORIZATION AND DAY LIMITS

intervention and reassessment that reasonably can be accomplished within the time frame of the additional days of coverage requested under the waiver provisions.

C. For patients in care at the time the partial hospitalization program limit is reached, a waiver must be granted prior to the limit. The contractor will handle the waiver requirement by asking for additional information during continued stay reviews. For patients being readmitted after having received 60 days in the fiscal year, the waiver review will be conducted at the time of the preadmission authorization.

VI. EXCEPTION

Effective October 1, 2003, TRICARE's preadmission and continued stay authorization is not required for inpatient mental health care for Medicare-TRICARE dual eligibles for the period when Medicare is primary payer and has authorized the care. **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.**

- END -