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**CHANGE 153  
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**SUMMARY OF CHANGE(S): See page 3.**

**EFFECTIVE DATE: See page 3.**

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

**CHANGE 153**  
**6010.57-M**  
**JANUARY 19, 2016**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 13.1, pages 1 and 2

**CHAPTER 4**

Section 5.3, pages 1-3

**CHAPTER 7**

Section 3.6, pages 1 - 4

Section 3.7, pages 1 - 5

**INSERT PAGE(S)**

Section 13.1, pages 1 and 2

Section 5.3, pages 1 and 2

Section 3.6, pages 1 - 4

Section 3.7, pages 1 - 5

## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 13.1.
  - a. This change clarifies coverage of programs called Intensive Outpatient Programs that are provided by TRICARE authorized freestanding or hospital-based PHP programs. EFFECTIVE DATE: For S9480, 01/01/2000.
  - b. This change updates the C and S code policy to reflect current HCPCS coding. EFFECTIVE DATE: 02/19/2016.

### **CHAPTER 4**

2. Section 5.3. This change updates and clarifies current coverage policy on prophylactic mastectomy by removing outdated and confusing language. EFFECTIVE DATE: 02/25/2015.

### **CHAPTER 7**

3. Section 3.6. This change clarifies coverage of programs called Intensive Outpatient Programs that are provided by TRICARE authorized freestanding or hospital-based PHP programs. EFFECTIVE DATE: For psychiatric IOP (S9480), 01/01/2000.
4. Section 3.7. This change clarifies coverage of programs called Intensive Outpatient Programs that are provided by TRICARE authorized freestanding or hospital-based PHP programs. EFFECTIVE DATE: For SUD IOP (H0015), 01/01/2001.



## Healthcare Common Procedure Coding System (HCPCS) "C" And "S" Codes

Issue Date: November 6, 2007  
Authority:

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### 1.0 HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### 2.0 DESCRIPTION

**2.1** HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

**2.2** HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

### 3.0 POLICY

**3.1** Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For Hospital Outpatient Department (HOPD) services provided on or before May 1, 2009 (implementation of TRICARE's OPPS), and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 24, paragraph 2.2](#).

**3.2** Under TRICARE, "S" codes are not reimbursable except as follows:

**3.2.1** S9122, S9123, S9124, and S8940 for the Extended Care Health Option (ECHO) respite care benefit and the ECHO Home Health Care (EHHC) benefit;

**3.2.2** S0812, S1030, S1031, S1040, S2083, S2202, S2235, S2325, S2360, S2361, S2401 - S2405, S2411, S3620, S8030, S8185, S8265, S8270, and S9430 for all beneficiaries; and

**3.2.3** S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 18, Section 8](#).)

**3.2.4** S2400 for prenatal surgical intervention of temporary tracheal occlusion of Congenital Diaphragmatic Hernia (CDH) for fetuses with prenatal diagnosis of CDH shall be determined on a

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case-by-case basis, based on the Rare Disease policy, effective October 1, 2009. Procedural guidelines for review of rare disease are contained in [Section 3.1](#).

**3.2.5** S0189 for testosterone pellets as provided in [Chapter 4, Section 5.1](#).

**3.2.6** S8999 for resuscitation bag for use by the patient on artificial respiration during power failure or other catastrophic event. The bag must be U.S. Food and Drug Administration (FDA) approved, used in accordance with FDA indications, and must be prescribed by a physician.

**3.2.7** S9900 for services rendered by an authorized Christian Science Practitioner as provided in [Chapter 11, Section 1.1](#).

**3.2.8** S0190 and S0191 as provided in [Chapter 4, Section 18.3](#).

**3.3** Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

**3.4** S2095 for the treatment of unresectable liver metastases from neuroendocrine tumors, as stated in [Chapter 1, Section 3.1](#).

**3.5** S5110 and S5115 are covered as part of the Applied Behavior Analysis (ABA) benefit as outlined in [Chapter 7, Section 3.18](#). The end date is December 31, 2014.

**3.6** S9480 as described in [Chapter 7, Section 3.6, paragraph 3.8](#) and [Chapter 7, Section 3.7, paragraph 3.3.1.2.3](#).

#### **4.0 EXCLUSIONS**

**4.1** HCPCS "C" codes are not allowed to be billed by independent professional providers.

**4.2** HCPCS S2066, S2067, and S2068 shall no longer be used. Current Procedural Terminology (CPT)<sup>1</sup> code 19364 is the more appropriate representation of these services.

- END -

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## Prophylactic Mastectomy, Prophylactic Oophorectomy, And Prophylactic Hysterectomy

Issue Date: October 25, 1993  
Authority: [32 CFR 199.4\(c\)\(2\)](#)

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### 1.0 CPT<sup>1</sup> PROCEDURE CODES

19300 - 19307, 58150 - 58294, 58541 - 58554, 58661, 58720, 58940 - 58956

### 2.0 DESCRIPTION

Prophylactic mastectomy, prophylactic oophorectomy, and prophylactic hysterectomy are surgical procedures that aim at completely removing organs or tissue in the absence of malignant disease to reduce the risk of individuals at high risk from developing cancer. A high risk individual is one with a family history of cancer in the breast and/or ovaries, or uterus; or personal history of cancer in the breast and/or ovaries. Carefully selected indications have been developed for prophylactic mastectomy and are included in this policy.

### 3.0 POLICY

**3.1** Bilateral prophylactic mastectomies are covered for patients at increased risk of developing breast carcinoma who have one or more of the following:

**3.1.1** Atypical hyperplasia of lobular or ductal origin confirmed on biopsy; or

**3.1.2** A history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (Family Cancer Syndrome). A positive Breast Cancer (BRCA) genetic test is not necessary; or

**3.1.3** Fibronodular, dense breasts which are mammographically and/or clinically difficult to evaluate and the patient presents with either of the above (or both) clinical presentations.

**3.2** Unilateral prophylactic mastectomies are covered when the contralateral breast has been diagnosed with cancer for patients with:

**3.2.1** Diffuse microcalcifications in the remaining breast, especially when ductal in-situ carcinoma has been diagnosed in the contralateral breast; or

**3.2.2** Lobular carcinoma in-situ; or

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**3.2.3** Large breast and/or ptotic, dense or disproportionately-sized breast that is difficult to evaluate mammographically and clinically; or

**3.2.4** In whom observational surveillance is elected for lobular carcinoma in-situ and the patient develops either invasive lobular or ductal carcinoma; or

**3.2.5** A history of breast cancer in multiple first-degree relatives and/or multiple successive generations of family members with breast and/or ovarian cancer (Family Cancer Syndrome). A positive BRCA genetic test is not necessary.

**3.3** Prophylactic oophorectomy is covered for women who meet any of the following criteria:

**3.3.1** Women who have been diagnosed with an hereditary ovarian cancer syndrome based on a family pedigree constructed by an authorized provider competent in determining the presence of an autosomal dominant inheritance pattern; or

**3.3.2** Women with a personal history of steroid hormone receptor-positive breast cancer; or

**3.3.3** Women with a personal history of breast cancer and at least one first degree relative (mother, sister, daughter) with a history of ovarian cancer; or

**3.3.4** Women who have two or more first degree relatives with a history of breast or ovarian cancer; or

**3.3.5** Women with one first degree relative and one or more second degree relative (grandmother, aunt, or niece) with ovarian cancer.

**3.3.6** Some families have pedigrees that are very small, and therefore have only one first degree relative with ovarian cancer or young-onset breast, colon, or endometrial cancer that may suggest increased risk for ovarian cancer. These individuals may also be considered for prophylactic oophorectomy. Effective January 1, 2006.

**3.4** Prophylactic hysterectomy is covered:

**3.4.1** For women who are about to undergo or are undergoing tamoxifen therapy.

**3.4.2** For women who have been diagnosed with Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or are found to be carriers of HNPCC-associated mutations.

- END -

## Psychiatric Partial Hospitalization Programs (PHPs) - Preauthorization And Day Limits

Issue Date: July 14, 1993

Authority: [32 CFR 199.4\(a\)\(12\)](#) and [\(b\)\(10\)](#)

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### 1.0 BACKGROUND

The Fiscal Year (FY) 1992 Defense Authorization Conference Report directed the Secretary of Defense to establish a partial hospitalization benefit. As a result, the partial hospitalization benefit, previously limited to treatment of alcoholism, was expanded to cover other mental health disorders. This added level of care improves the availability of mental health services. The intent is to provide a needed service at a lower cost than the full hospitalization rate, and to allow more efficient use of resources for needed mental health care.

### 2.0 DESCRIPTION

Psychiatric partial hospitalization is a treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least three hours per day, five days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. To be approved, such programs must enter into a participation agreement, and be accredited and in substantial compliance with the Joint Commission's **Mental Health Manual** (formerly **Consolidated Standards Manual**).

### 3.0 POLICY

**3.1** Preadmission and continued stay authorization is required for all admissions to a psychiatric Partial Hospitalization Program (PHP) without exception, as the concept of an emergency admission does not pertain to a partial hospitalization level of care. Preauthorization is required even if the facility is transferring a patient to a lower level of care within its own structure.

**3.2** The admission criteria shall not be considered fulfilled unless the patient has been personally evaluated prior to the admission by a physician or other authorized health care professional with admitting privileges operating within the scope of his/her license.

**3.3** Day Limits for Psychiatric Partial Hospitalization. The benefits for institutional services for psychiatric partial hospitalization are limited to 60 treatment days (whether a full day or partial day program) in a fiscal year or in an admission. This limit may be extended by waiver. The 60 treatment days are not offset by or counted toward the 30-45 day inpatient limit.

**3.4** Criteria for determining medical or psychological necessity of psychiatric partial hospitalization services. Psychiatric partial hospitalization services will be considered necessary only if all of the following conditions are present:

**3.4.1** The patient is suffering significant impairment from a mental disorder (as defined in [32 CFR 199.2](#)) which interferes with age appropriate functioning.

**3.4.2** The patient is unable to maintain himself or herself in the community, with appropriate support, at a sufficient level of functioning to permit an adequate course of therapy exclusively on an outpatient basis (but is able, with appropriate support, to maintain a basic level of functioning to permit partial hospitalization services and presents no substantial imminent risk of harm to self or others).

**3.4.3** The patient is in need of crisis stabilization, treatment of partially stabilized mental health disorder, or services as a transition from an inpatient program.

**3.4.4** The admission into the PHP is based on the development of an individualized diagnosis and treatment plan expected to be effective for that patient and permit treatment at a less intensive level.

**3.5** Claims for outpatient psychotherapy provided during the period a patient is participating in a PHP are to be denied as "noncovered services". Professional services provided by an attending physician that do not duplicate treatment provided in a PHP may be billed separately.

**3.6** Outpatient psychotherapy services provided by a PHP after the patient's care has been denied or after the patient has been discharged, are not a benefit of the PHP. Partial hospitalization is an institutional benefit, not a professional services benefit. The PHP services provided by the institutional provider are covered by the all-inclusive per diem rate when authorized. If authorization is denied due to the PHP stay not being medically necessary or appropriate, none of the services related to that stay are payable regardless of how they are billed. Psychotherapy services provided by a PHP after a patient has been discharged from the PHP are not part of the partial hospitalization benefit nor is the PHP an authorized provider under TRICARE for these outpatient services.

**3.7** Authorized PHPs have entered into participation agreements to provide multi-disciplinary programs in exchange for all-inclusive per diem reimbursement. Any attempt by a PHP to carve out certain services and bill on a fee-for-service basis would be considered a violation of that agreement.

**3.8** PHPs may also provide a service they call "Intensive Outpatient Program" or IOP. Freestanding and hospital-based PHPs may provide partial hospitalization services, also referred to as IOP, provided less than five days per week, at least three hours per day but less than six hours per day, with reimbursement occurring at half-day PHP rate (i.e., three to five hours), in accordance with the TRICARE Reimbursement Manual (TRM), [Chapter 7, Section 2](#); [TRM, Chapter 7, Addendum B](#); and [TRM, Chapter 13, Section 2](#). IOPs must be provided by a TRICARE-certified PHP. All program policies that apply to TRICARE-certified PHPs shall also apply to the IOPs provided by PHPs.

## 4.0 POLICY CONSIDERATIONS

### 4.1 Payment Responsibility.

**4.1.1** Any care in a psychiatric PHP 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:

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

**4.1.1.2** 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.

**4.1.2** 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.

**4.2** 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 (EOC). 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.

## 5.0 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.

**5.1** The criteria for waiver are set forth in [paragraph 3.0](#). 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.

**5.2** 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 (LOS) beyond the date of the 60-day limit. There must be evidence of a coherent and specific plan for assessment, intervention and

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

**5.3** For patients in care at the time the PHP 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.

**6.0 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.

**7.0 EXCLUSION**

IOP services rendered by a provider that is not TRICARE-authorized (i.e., IOPs that are not TRICARE-authorized hospital-based or freestanding PHPs).

- END -

## Substance Use Disorders

Issue Date: June 26, 1995

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)\(A\)](#), [\(e\)\(4\)](#), and [\(h\)](#)

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### 1.0 DESCRIPTION

Complication of alcohol and/or drug use or dependency and detoxification.

### 2.0 POLICY

Coverage may be extended for the treatment of substance use disorders including detoxification, rehabilitation, and outpatient care provided in authorized Substance Use Disorder Rehabilitation Facilities (SUDRFs) in accordance with the [paragraph 3.0](#).

### 3.0 POLICY CONSIDERATIONS

#### 3.1 Emergency And Inpatient Hospital Services

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

**3.1.2** 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.

**3.1.3** Stays provided for substance use disorder rehabilitation in a hospital-based facility are covered when provided as outlined in [paragraph 3.2](#).

**3.1.4** Inpatient hospital services are subject to the provisions regarding the limit on inpatient mental health services.

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

#### 3.2 Authorized Substance Use Disorder Treatment

**3.2.1** Only those services provided by an 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 SUDRF.

**3.2.2** A qualified mental health provider (physicians, clinical psychologists, Clinical Social Workers (CSWs), and psychiatric nurse specialists) shall prescribe the particular level of treatment.

**3.2.3** Each 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 3.5](#).

**3.2.3.1** 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.

**3.2.3.2** Emergency and inpatient hospital services as described under [paragraph 3.1.1](#), do not constitute substance use treatment for the purposes of establishing the beginning of a benefit period.

**3.2.3.3** Unused benefits cannot be carried over to subsequent benefit periods.

### **3.3 Covered Services**

**3.3.1** Rehabilitative care in an authorized hospital or SUDRF, whether freestanding or hospital-based, is covered on either a residential or partial care (day, evening or weekend) basis.

**3.3.1.1** Residential Care is subject to the following:

**3.3.1.1.1** Care must be preauthorized.

**3.3.1.1.2** Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of stays classified in Diagnosis Related Group (DRG) 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to 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 3.5](#).

**3.3.1.1.3** 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 seven days, unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

**3.3.1.1.4** The medical and psychological necessity of the detoxification must be documented. Any detoxification services provided in the SUDRF must be under general medical supervision.

**3.3.1.2** Partial care is subject to the following:

**3.3.1.2.1** Care must be preauthorized

**3.3.1.2.2** Coverage during a single benefit period is limited to 21 days unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

**3.3.1.2.3** TRICARE authorized SUDRFs may also provide a service they call "Intensive Outpatient Program" or IOP. SUDRFs may provide partial substance use disorder services, also referred to as IOP, provided less than five days per week, at least three hours per day but less than six hours per day, with reimbursement occurring at the half-day PHP rate (i.e., three to five hours), TRICARE Reimbursement Manual (TRM), Chapter 7, Section 2; TRM, Chapter 7, Addendum B; and TRM, Chapter 13, Section 2. IOPs shall be provided by a TRICARE-certified SUDRF. All program policies that apply to TRICARE-certified SUDRFs also apply to the IOPs provided by SUDRFs.

**3.3.2** Outpatient care is subject to the following:

**3.3.2.1** Outpatient care (substance use disorder) must be provided by an approved SUDRF, whether freestanding or hospital-based. Certified addiction rehabilitation counselors or certified alcohol counselors employed by an authorized hospital or a SUDRF may provide the care.

**3.3.2.2** The SUDRF must bill for the services using the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Payment is the lesser of the billed amount or the CHAMPUS Maximum Allowable Charge (CMAC).

**3.3.2.3** Coverage is up to 60 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

**3.3.2.4** Outpatient care is covered in both individual and group settings, in an authorized hospital or freestanding or hospital-based SUDRF. For patients with a primary diagnosis of mental disorder (**Diagnostic and Statistical Manual of Mental Disorders** (DSM)) that coexists with an alcohol and other drug abuse disorder see [Section 3.13](#).

**3.3.2.5 Opioid Replacement Treatment**

Effective November 21, 2013, opioid replacement treatment is covered for the treatment of substance use disorders. Opioid replacement treatment involves the substitution of a therapeutic drug with addictive potential for a drug of addiction. Benefit limits stated in [paragraph 3.3.1.2](#) or [paragraph 3.3.2.3](#) apply unless waived in accordance with [Section 3.5](#) of this Chapter.

**3.3.3** Family Therapy.

**3.3.3.1** Family therapy provided on an outpatient basis by an approved SUDRF, whether freestanding or hospital-based, is covered beginning with the completion of the patient's rehabilitative care as outlined in [paragraph 3.3.1](#). 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 3.5](#). Services provided on an outpatient basis will be reimbursed under the appropriate allowable charge for the procedure code(s) billed.

**3.3.3.2** Family therapy must be provided by a qualified mental health provider (psychiatrists or other physicians, clinical psychologists, Certified Psychiatric Nurse Specialists (CPNS), certified clinical social workers, TRICARE certified mental health counselors, certified marriage and family therapists; and pastoral and supervised mental health counselors, under a physician's supervision).

**3.4 Coverage Limitations**

**3.4.1** 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).

**3.4.2** Rehabilitation. Rehabilitation stays are subject to a limit of three benefit periods in a lifetime unless this limit is waived. Preadmission and continued stay authorization is required for

substance use disorder detoxification and rehabilitation. 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.

**Note:** The beneficiary may have either 21 days of rehabilitation in 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.

### **3.5 Waiver Of Benefit Limits**

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

**3.5.1** Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

**3.5.2** Further progress has been delayed due to the complexity of the illness.

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

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

### **3.6 Payment Responsibility**

Providers may not hold patients liable for payment for services for which 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 payment would not be made. Any such effort to seek payment is a basis for termination of the provider's authorized status.

**3.7** Coverage is allowed for Antabuse® in the treatment of alcoholism.

### **3.8 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 United States Code (USC) 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 contractor necessary to determine benefits on a claim for treatment of substance use disorder the claim will be denied.

## **4.0 EXCEPTIONS**

**4.1** 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.

**4.2** 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.

**5.0 EXCLUSION**

IOP services rendered by a provider that is not TRICARE-authorized (i.e., IOPs that are not TRICARE-authorized hospital-based or freestanding SUDRFs).

- END -

