

CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 18.10
TITLE: PREAUTHORIZATION REQUIREMENTS FOR ACUTE HOSPITAL
PSYCHIATRIC CARE

AUTHORITY: 38 CFR 17.270(a) and 17.272(a)

RELATED AUTHORITY: P.L. 101-510, P.L. 101-511 32 CFR 199.4(b)(6)(i)(iii)

I. EFFECTIVE DATE

A. October 1, 1991, for inpatient services.

B. October 1, 2003, for waiver of preauthorization, where Medicare is primary payer and has authorized the care.

II. POLICY

A. Effective October 1, 1991 pre-admission and continued stay authorization is required before non-emergency inpatient mental health services may be cost shared. Prompt continued stay authorization is required after emergency admissions. To comply with the statutory requirements and to avoid denial, requests for pre-admission authorization on weekends and holidays are discouraged. Admission criteria requires that the patient be personally evaluated by a physician or other authorized health care professional (with admitting privileges) to the facility to which the patient is being admitted.

B. Effective October 1, 2003, preauthorization of inpatient mental health care is no longer required for Medicare eligible beneficiaries when Medicare is the primary payer and has authorized the care. Medicare beneficiaries who are also CHAMPVA eligible are required to follow Medicare's rules until their Medicare benefit is exhausted. Once the Medicare benefit is exhausted, CHAMPVA preauthorization is required.

III. POLICY CONSIDERATIONS

A. Treatment of Mental Disorders. To qualify for CHAMPVA mental health benefits, the patient must be diagnosed by a CHAMPVA-authorized licensed, qualified mental health professional and be suffering from a mental disorder, according to the criteria listed in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. 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 certain V codes specifically listed in DSM-III-R. A mental disorder is considered to be medically or psychologically necessary, when the patient, because of their diagnosed mental disorder, experiences both physical or psychological distress with an impairment in their ability to function in appropriate occupational, educational or social roles. The degree to which the patient's ability to function is impaired usually determines the level of care (if any) needed to treat the patient's condition.

B. Criteria for Determining Medical or Psychological Necessity. The Director, CHAMPVA Center (or designee) shall evaluate and determine the medical or psychological necessity of acute inpatient mental health services and will consider the appropriate level of care for the inpatient, the intensity of services required by the patient, and the availability of that care. The purpose of such care is to stabilize a life-threatening or severely disabling condition within the context of a brief, intensive model of inpatient care in order to permit management of the patient's condition at a less intensive level of care. Such care is appropriate, when the care is generally recognized as being effectively and safely provided, only in an acute inpatient hospital setting. Acute inpatient care shall not be considered necessary unless the patient:

1. needs to be observed and assessed on a 24-hour basis by skilled nursing staff, and/or
2. requires continued intervention by a multidisciplinary treatment team; and in addition, at least one of the following criteria is determined to be met:
 - a. patient poses a serious risk of harm to self and/or others,
 - b. patient is in need of high dosage, intensive medication or somatic and/or psychological treatment, with potentially serious side effects, and
 - c. patient has acute disturbances of mood, behavior, or thinking.

C. Emergency Admissions. Admission to an acute inpatient hospital setting may be on an emergency or on a non-emergency basis. In order for an admission to qualify as an emergency, all of the following criteria, in addition to those in Paragraph B. above must be met.

1. The patient must be at immediate risk of serious harm to self and/or others based on a psychiatric evaluation performed by a physician (or other qualified mental health professional with hospital admission authority).
2. The patient requires immediate continuous skilled observation and treatment at the acute psychiatric level of care.

D. Preauthorization Requirements. All non-emergency admissions **for acute inpatient hospital level care must be preauthorized**. The criteria for preauthorization is set forth in Paragraph III, Policy Considerations B. 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.

1. The timetable for development of the individualized treatment plan shall be as follows.
 - a. The development of the plan must begin immediately upon admission.
 - b. A preliminary treatment plan must be established within 24 hours of the admission.
 - c. A master treatment plan must be established within five calendar days of the admission.
2. The elements of the individualized treatment plan must include:
 - a. the diagnostic evaluation that establishes the necessity for the admission;
 - b. an assessment regarding the appropriateness of services at a less intensive level of care;
 - c. a comprehensive biopsychosocial assessment and diagnostic formulation;
 - d. a specific individualized treatment plan that integrates measurable goals/objectives and their required level of care for each of the patient's problems that are a focus of treatment;
 - e. a specific plan for involvement of family members, unless therapeutically contraindicated; and
 - f. a discharge plan, including an objective of referring the patient to further services, if needed, at less intensive levels of care within the benefit limit period.

3. The request for preauthorization must be received by the Director, Health Administration Center (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 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. If the care is found not medically necessary, however, and is not approved, the provider is liable for the services but has the right to appeal the "not medically necessary" determination.

4. Authorization prior to admission is not required in the case of a psychiatric 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 psychiatric emergency should be reported within 24 hours of the admission or the next business day after the admission, and must be reported to the Director, Health Administration Center, (or designee), within 72 hours of the admission. In the case of an emergency admission authorization resulting from approval of a request made within 72 hours of the admission, the effective date of the authorization shall be the date of the admission. However, if it is determined that the case was not a bona fide psychiatric emergency admission (but the admission can be authorized as medically or psychologically necessary), the effective date of the authorization shall be the date of the receipt of the request.

5. Pre-admission authorization is required even when the beneficiary has other health insurance because the statutory requirement is applicable to every case in which CHAMPVA payment is sought, regardless of whether it is first payer or second payer basis.

E. Payment Responsibility. If a request for waiver of the day limitations is filed and the waiver is not granted by the Director, Health Administration Center (or designee) benefits will only be allowed for the period of care authorized.

F. Concurrent Review. Concurrent review of the necessity for continued stay will be conducted at least every 7 days and authorized in increments of no greater than 7 days. The criteria for concurrent review shall be those set forth in Paragraph B under Policy Considerations above. 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.

END OF POLICY