

CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 18.16
TITLE: PREAUTHORIZATION REQUIREMENTS FOR SUBSTANCE USE
DISORDERS DETOXIFICATION AND REHABILITATION

AUTHORITY: 38 CFR 17.270(a), 17.272(a) and 17.273

RELATED AUTHORITY: 32 CFR 199.4(6)(i), PL. 101-510, and PL. 101-511

I. EFFECTIVE DATE

A. Effective October 1, 1991, inpatient services.

B. Effective October 1, 2003, 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 services for substance use may be cost-shared. Pre-admission and continued stay authorization is required for both detoxification and rehabilitation services. To comply with the statutory requirements and to avoid denial, requests for pre-admission 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.

B. Effective 1 October, 2003, preauthorization of inpatient mental health care is no longer required for Medicare eligible beneficiaries when Medicare is 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 licensed, qualified mental health professional as suffering from a mental health 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 psychological necessary, **when** the patient, **because of their** diagnosed mental disorder, experiences both physical or psychological distress **and** an impairment in his or her 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. Admissions occurring on or after October 1, 1991, to all facilities (includes DRG and non-DRG facilities):

1. Detoxification. Stays for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the new statutory day limit which goes into effect October 1, 1991, 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). In determining the medical or psychological necessity of detoxification and rehabilitation for substance abuse, the evaluation conducted by the Director, Health Administration Center, (or designee), 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 substance use disorder. 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 should be reported within 24 hours of the admission or the next business day after the admission, but must be reported to the reviewer designated by the Center Director, within 72 hours of the admission. 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 substance use disorder facility are limited to 7 days unless the limit is waived by the Director, Health Administration Center or a designee, and must be provided under general medical supervision.

2. Rehabilitative care. The patient's condition must be such that rehabilitation for substance abuse must be provided in a hospital or in an organized inpatient substance use 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 (exclusive of stays classified in DRG 433) in hospitals subject to the CHAMPVA DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitative care unless the limit is waived by the Director, Health Administration Center or a designee. Days of rehabilitation must be counted toward the new 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.

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. The Director, Health Administration Center (or designee) may grant an exception to the requirement for preauthorization if the services otherwise would be payable except for the failure to obtain preauthorization.

4. Pre-admission authorization is requested 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.

C. Payment Responsibility.

1. Any inpatient mental health care obtained without requesting pre-admission 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 CHAMPVA 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 by CHAMPVA. The beneficiary must agree, in writing, to personally pay for the non-CHAMPVA 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 Director, Health Administration Center or a designee, CHAMPVA benefits will only be allowed for the period of care authorized.

3. Waiver review of the necessity for continued stay will be conducted. For care provided under the CHAMPVA DRG-based payment system, waiver review will be conducted only when the care falls under the DRG long-stay outlier. The criteria for waiver review shall be those set forth in Paragraph B under Policy Considerations above.

D. In applying those criteria in the context of waiver 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 waiver 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 only (not the reimbursement of services), 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.

END OF POLICY