ValueOptions - TRICARE SUBSTANCE USE WAIVER OF BENEFIT LIMIT REQUEST

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Substance Use Rehabilitation (Inpatient Rehabilitation, Partial Hospitalization Rehabilitation or Outpatient Group Treatment) care is appropriate for those patients whose addiction related symptoms or concomitant physical and emotional/behavioral problems result in physical or psychological distress and an impairment in his or her ability to function in appropriate occupational, educational and social roles. There is a **statutory** limit of 21 days, 60 outpatient group sessions, per 365 day benefit period and three (3) benefit periods in a lifetime. However, in special cases, after confirming that applicable criteria have been met, the benefit limit(s) may be waived and payment authorized.

The clinician responsible for the patient's care is responsible for documenting that a waiver criterion has been met and must establish an estimated length of stay. There must be evidence of a coherent and specific plan for assessment, intervention and reassessment that **reasonably can be accomplished within the time frame** of the additional days of coverage requested under the waiver provision. The waiver may be granted if determined to be medically or psychologically necessary.

Special emphasis shall be placed on determining whether additional Substance Use Rehabilitation benefits are medically/psychologically necessary to complete necessary elements of the treatment plan prior to implementing appropriate discharge planning. A waiver may also be granted in cases in which a patient exhibits well documented **new** symptoms, maladaptive behavior, or medical complications which have appeared in the treatment setting requiring a significant revision to the treatment plan.

IDENTIFYING DATA

Patient's Name_____ Sponsor # _____ DOB_____

Facility Name_____ Telephone_____ Fax#_____

Provider Name_____ Telephone _____

DSM-IV DIAGNOSIS

Axis I /__/__/__/ - /__/__/ /__/__/__/ - /__/__/ Axis II /__/__/__/ - /__/__/ Axis III _____Axis IV_____Axis V: Current _____

Specific plan that can reasonably be accomplished within a limited waiver period:_____

_____

_____

_____

New symptoms/maladaptive behavior/medical complications:_____

_____

_____

Expected Outcome & Prognosis:_____

_____

Requested waiver due to: (Check all applicable)
Day limit - list # of days/session requested:_____ **Waiver of lifetime benefits: _____** **Waiver due to substance use care within the past 365 days: _____**

_____ _____

Rendering Physician's Signature **Date** **Print Treating Provider's Name** **09/12/06**