

ValueOptions - TRICARE PSYCHIATRIC PHP WAIVER OF BENEFIT LIMIT REQUEST

P.O. Box 551188, Jacksonville, FL 32225-1188 Fax: 866-811-4422

Psychiatric Partial Hospitalization care is appropriate for those patients whose psychiatric symptoms can be managed outside the hospital environment for defined periods of time with support. There is a **statutory presumption** against the appropriateness of psychiatric partial hospitalization services in excess of the 60 day limit. However, in special cases, after confirming that applicable criteria have been met, the benefit limit 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 Psychiatric Partial Hospitalization 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:
Day limit - list # of days requested: _____

Rendering Physician's Signature

Date

Print Treating Provider's Name

09/08/06