

VALUEOPTIONS/TRICARE RESIDENTIAL TREATMENT CENTER (RTC) WAIVER OF BENEFIT LIMIT REQUEST

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In order for treatment of a mental disorder to be medically or psychologically necessary, the patient must, as a result of a diagnosed mental disorder, be experiencing both 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 presumption** against the appropriateness of RTC services in excess of the 150 day limit. However, the contractor for behavioral health services, ValueOptions, may in **special** cases according to TRICARE policy Chapter 7, Section 3.2 waive the RTC benefit limit and authorize payment for care beyond that limit.

It is the responsibility of the patient’s attending clinician to establish, through actual documentation from the medical record and other sources that the conditions for waiver exist. The waiver request must include specific time frames and a specific plan of treatment which will lead to discharge. Special emphasis shall be placed on determining whether additional days of RTC care 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’s progress is insufficient, due to the complexity of the illness, specific evidence is presented to explain the factors which interfered with treatment progress during the 150 days.

Where family or social issues complicate transfer to a lower level of intensity, the RTC is responsible for determining and arranging the supportive and adjunctive resources required to permit appropriate transfer. If the RTC fails adequately to meet this responsibility, the existence of such family or social issues shall be an inadequate basis for a waiver of the benefit limit. The waiver **may** be granted if determined to be medically or psychologically necessary.

IDENTIFYING DATA

Patient’s Name _____ Sponsor # _____ ID# _____ 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 length of stay beyond the 150 day limit: _____

Treating Provider’s Signature

Date