BEHAVIORAL HEALTH SPECIFIC REFERRAL CHECKLIST

All referrals and authorization requests require the TRICARE West Region "Submit Referral/Authorization Form" found on Availity in the TRICARE West payer space. In addition, Behavioral Health specific requests require an associated checklist. Please click on the treatment being requested below and complete the hyperlinked behavioral health referral/authorization checklist to accompany your request:

1. Emergency Inpatient Psychiatric Admission (must notify TriWest within 1 business day of admission)
2. Non-Emergency Inpatient Psychiatric Admission (Pre-Authorization Required)
3. Acute Inpatient Psychiatric Admission Continued Stay (Pre-Authorization Required)
4. Emergency Inpatient Detoxification (must notify TriWest within 1 business day of admission)
5. Non-Emergency Inpatient Detoxification (Pre-Authorization Required)
6. Inpatient Detoxification Continued Stay (Pre-Authorization Required)
7. Child under age 21 Residential Treatment Center (RTC) Admission (Pre-Authorization Required)[1]
8. Substance Use Disorder (SUD) Residential Facility (SUDRF) Admission (Pre-Authorization Required)[1]
9. RTC/SUDRF Continued Stay (Pre-Authorization Required)
10. Partial Hospitalization Program (PHP) Admission (PCM Referral or Pre-Authorization Required)
11. PHP Continued Stay (Pre-Authorization Required)
12. Intensive Outpatient Program (IOP) Admission (PCM Referral or Pre-Authorization Required)
13. IOP Continued Stay (Pre-Authorization Required)
14. Psychological/Neuropsychological Testing (Pre-Authorization Required)
15. Esketamine (Pre-Authorization Required)
16. Transcranial Magnetic Stimulation (TMS) for Depression (Pre-Authorization Required)
17. Electroconvulsive Therapy (Pre-Authorization Required)

Per the TRICARE Policy Manual, Chapter 7, Section 3.2, Non-SUD residential treatment is only a covered benefit for beneficiaries under the age of 21. Beneficiaries 21 and over may be approved to attend SUDRFs. However, non-SUD residential care for adults (including active duty), are not a covered benefit. Admission to sub-acute inpatient specialty programs may be approved on a week-to-week basis as non-emergency psychiatric admissions if medical necessity can be proven but will not be approved as residential admissions.

BEHAVIORAL HEALTH SPECIFIC REFERRAL CHECKLIST

IMPORTANT NOTES

Please read the following important items regarding behavioral health specific referrals:

- Outpatient mental health services do not require a referral or pre-authorization except for Active duty service members (ADSMs), who require a referral from their Primary Care Manager (PCM).
- Military Treatment Facilities (MTF) submit requests via MHS GENESIS. Submissions must include a level of detail to ensure the outlined medical necessity requirements are met or should include accompanying documentation as outlined on the associated checklist.
- TRICARE does not limit annual hospital days for psychiatric admissions.
- Requests for admissions must include an in-person assessment by a licensed physician or mental health provider. **Phone triage or RN acceptance notes are not acceptable.**
- The beneficiary must be diagnosed with a mental disorder recognized by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD), which includes Substance Use Disorders (SUDs).
- To meet medical necessity criteria, documentation of both symptoms and impairment is required.
- Interventions/Conditions not covered include, but are not limited to:
  - Educational testing
  - Learning disorders
  - Paraphilias
  - Sex therapy
  - Couples/marital therapy
  - DSM/ICD-9 V codes
  - ICD-10 Z codes
  - Conditions not attributed to a mental disorder
  - TMS for conditions other than depression
  - Stellate ganglion blockade
  - Ketamine treatment for psychiatric conditions

EMERGENCY PSYCHIATRIC ADMISSION CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as an emergency room assessment or a mental health evaluation.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.1, authorizes coverage of acute hospital psychiatric care when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD.
- ☐ Poses an **immediate** risk of **serious** harm to self or others, as assessed **by the admitting clinician**, *and* —
- ☐ Requires imminent, continuous, skilled observation and treatment at the acute psychiatric level of care, *and* —
- ☐ Needs high-dosage, intensive medication or somatic and/or psychological treatment with potentially serious side effects, *or* —
- ☐ Has an acute disturbance of mood, behavior, and or thinking.

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

NON-EMERGENCY PSYCHIATRIC ADMISSION CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as crisis assessment note, Emergency Room evaluation, recent clinician progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.1, authorizes coverage of acute hospital psychiatric care when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD.
- ☐ Requires continuous, skilled observation and assessment by skilled nursing staff, *or* —
- ☐ Requires continued intervention by a multidisciplinary treatment team, *plus one of the following*:
  - ☐ Poses **serious** risk of harm to self or others, as assessed **by the admitting clinician**
  - ☐ Needs high-dosage, intensive medication or somatic and/or psychological treatment with potentially serious side effects
  - ☐ Has an acute disturbance of mood, behavior, and or thinking

Desired date of admisison (MM/DD/YYYY):
Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

ACUTE PSYCHIATRIC ADMISSION CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.1, authorizes coverage of acute hospital psychiatric care when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD
- ☐ Still requires continuous, skilled observation and assessment by skilled nursing staff, *or* —
- ☐ Still requires continued intervention by a multidisciplinary treatment team, *plus one of the following:*
  - ☐ Still poses **serious** risk of harm to self or others, as assessed **by the treating clinician**
  - ☐ Still needs high-dosage, intensive medication or somatic and/or psychological treatment with potentially serious side effects
  - ☐ Continues to demonstrate an acute disturbance of mood, behavior, and or thinking

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

EMERGENCY INPATIENT DETOXIFICATION CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting document that show medical necessity, such as Emergency Room Assessment, Psychiatrist Assessment/H & P, vital signs, nursing notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Emergency Inpatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable Substance Use Disorder (SUD) recognized by the latest version of the DSM or ICD
- ☐ Requires the personnel and facilities of a hospital for medical stabilization or to treat active medical complications of intoxication or withdrawal

Date of admission (MM/DD/YYYY):	Date of discharge (MM/DD/YYYY) *(if already discharged)*:
Additional information:	

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

NON-EMERGENCY INPATIENT DETOXIFICATION CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as mental health provider assessment note, Emergency Room evaluation, recent clinician progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Non-Emergency Inpatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable Substance Use Disorder (SUD) recognized by the latest version of the DSM or ICD
- ☐ Will require the personnel and facilities of a hospital to treat the medical complications of their SUD and to mitigate potential medical complications of withdrawal following admission

Desired date of admission (MM/DD/YYYY):
Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

INPATIENT DETOXIFICATION CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with recent document that show continued medical necessity, such as recent clinician progress notes, nursing notes, vital signs, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of Inatient Detoxification when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable SUD recognized by the latest version of the DSM or ICD
- ☐ Still requires the personnel and facilities of a hospital to treat the medical complications of their SUD and to mitigate medical complications of withdrawal

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

CHILD UNDER AGE 21 RESIDENTIAL TREATMENT CENTER (RTC) ADMISSION CHECKLIST[1]

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, clinician progress notes, nursing notes (if currently inpatient), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.2, authorizes coverage of RTC admissions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD
- ☐ Is under 21 years old
- ☐ Exhibits patterns of disruptive behavior with disturbances in family functioning or social relationships and persistent psychological/emotional disturbances
- ☐ Cannot be safely managed at a lower level of care
- ☐ Is anticipated to receive active clinical treatment and an individualized treatment plan that will provide a specific level of care, measurable and relevant goals, skilled interventions by qualified mental health professionals, time frames for achieving proposed outcomes, timely reviews and updates to the treatment plan that reflect thoughtful alterations in the treatment regimen, goals, and level of care required for each problem, and explanations of any failure to achieve the treatment goals and objectives
- ☐ Parent(s)/guardian(s) agree to participate in regular family therapy unless contraindicated

Desired date of admission (MM/DD/YYYY):
Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

Per the TRICARE Policy Manual, Chapter 7, Section 3.2, Non-SUD residential treatment is only a covered benefit for beneficiaries under the age of 21. Beneficiaries 21 and over may be approved to attend SUDRFs. However, **non-SUD residential care for adults (including active duty), are not a covered benefit**. Admission to sub-acute inpatient specialty programs may be approved on a week-to-week basis as non-emergency psychiatric admissions if medical necessity can be proven but will not be approved as residential admissions.

SUBSTANCE USE DISORDER RESIDENTIAL FACILITY (SUDRF) ADMISSION CHECKLIST[1]

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, SUD history, clinician progress notes, nursing notes (if currently inpatient), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.3, authorizes coverage of SUDRF admissions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable Substance Use Disorder recognized by the latest version of the DSM or ICD
- ☐ Is at least 18 years of age
- ☐ Exhibits signs and symptoms of sufficient clinical severity to warrant residential treatment, or has failed SUD treatment services provided at a lower level of care
- ☐ Is anticipated to receive active clinical treatment and an individualized treatment plan that will provide a specific level of care, measurable and relevant goals, skilled interventions by qualified mental health professionals, time frames for achieving proposed outcomes, timely reviews and updates to the treatment plan that reflect thoughtful alterations in the treatment regimen, goals, and level of care required for each problem, and explanations of any failure to achieve the treatment goals and objectives.

Desired date of admission (MM/DD/YYYY):
Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

Per the TRICARE Policy Manual, Chapter 7, Section 3.2, Non-SUD residential treatment is only a covered benefit for beneficiaries under the age of 21. Beneficiaries 21 and over may be approved to attend SUDRFs. However, **non-SUD residential care for adults (including active duty), are not a covered benefit**. Admission to sub-acute inpatient specialty programs may be approved on a week-to-week basis as non-emergency psychiatric admissions if medical necessity can be proven but will not be approved as residential admissions.

RESIDENTIAL TREATMENT (RTC/SUDRF) CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.4, authorizes coverage of PHP admissions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD, which includes Substance Use Disorders (SUDs)
- ☐ Is in need of crisis stabilization, treatment of a partially stabilized mental health disorder or SUD, or requires intensive clinical services following discharge from an inpatient program
- ☐ Is suffering significant impairment from a mental disorder/SUD that interferes with age-appropriate functioning, *or–*
- ☐ Is in need of clinically intensive rehabilitative programming and medical monitoring to manage withdrawal symptoms from alcohol, sedative-hypnotics, opioids, or stimulants
- ☐ Is unable to maintain adequate functioning to engage in a course of outpatient therapy
- ☐ Is able, with appropriate support, to maintain a basic level of functioning to permit PHP services
- ☐ Has no substantial imminent risk of harm to self or others

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

PARTIAL HOSPITALIZATION PROGRAM (PHP) CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show continued medical necessity, such as recent progress notes, treatment plan updates, vital signs (for eating disorder patients), etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.4, authorizes coverage of Partial Hospitalization Program (PHP) continued stay when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD, which includes Substance Use Disorders (SUDs)
- ☐ Continues to require PHP-level support to maintain sobriety or clinical stability
- ☐ Is actively participating in PHP programming, to include following most program rules when able
- ☐ Is receiving active clinical treatment, i.e., skilled interventions by qualified professionals
- ☐ Has an individualized treatment plan that includes the indicated level of care, measurable goals, time frames for achieving them, timely reviews/updates, feasibility of family therapy (for children and adolescents), and explanations of any failure to achieve the treatment goals and objectives

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

INTENSIVE OUTPATIENT PROGRAM (IOP) ADMISSION CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychosocial assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.15, authorizes coverage of Intensive Outpatient Program (PHP) admissions when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD, which includes Substance Use Disorders (SUDs)
- ☐ Is experiencing significant impairment that interferes with age-appropriate functioning
- ☐ Is in need of crisis stabilization, treatment of a partially stabilized mental health disorder or SUD, or requires transition services following discharge from an inpatient program
- ☐ Requires more intensive treatment than would be available in a typical outpatient environment, but is sufficiently stable so as not to warrant Partial Hospitalization (e.g., IOPs typically provide 6-9 hours of programming a week, with a minimum of 2 hours per treatment day)
- ☐ Is expected to receive an individualized treatment plan that is expected to be effective for the patient and permit treatment at the least intensive level

Desired date of admission (MM/DD/YYYY):
Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

INTENSIVE OUTPATIENT PROGRAM (IOP) CONTINUED STAY CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show continued medical necessity, such as recent progress notes, treatment plan updates, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.15, authorizes coverage of Intensive Outpatient Program (PHP) continued stay when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a diagnosable non-V/Z Code condition recognized by the latest version of the DSM or ICD, which includes Substance Use Disorders (SUDs)
- ☐ Continues to require IOP-level support to maintain sobriety and/or clinical stability
- ☐ Is actively participating in IOP programming, to include following most program rules when able
- ☐ Is receiving active clinical treatment, i.e., skilled interventions by qualified professionals
- ☐ Has an individualized treatment plan that is effective for the patient and is permitting treatment at the least intensive level

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

PSYCHOLOGICAL/ NEUROPSYCHOLOGICAL TESTING CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as recent medical or psychological evaluation, progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.9, authorizes coverage of Psychological/Neuro-psychological testing when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Has a documented mental status exam in their medical chart
- ☐ Has been determined to need at least one of the following conditions (check all that apply):
  - ☐ A diagnostic assessment (as required for the Autism Care Demonstration program)
  - ☐ An assessment of baseline cognitive functioning
  - ☐ Repeat testing to assess change from baseline
  - ☐ Testing to clarify or inform an existing diagnosis
  - ☐ An evaluation of functional deficits
  - ☐ An assessment of lack of treatment response

THE TESTING:

- ☐ Will not include a Reitan-Indiana battery for patients under 5, or under 13 when self-administered
- ☐ Will not be conducted for any of the following reasons:
  - Academic placement
  - Determining the presence and/or nature of a learning disorder
  - Influencing custody determinations or job placements
  - General screening in the absence of psychiatric symptoms
  - Teachers or parents have requested it
  - Placement in a Residential Treatment Center (RTC) or Partial Hospitalization Program (PHP)
  - When billed by a provider not employed by or under contract with the patient's RTC or PHP

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

ELECTROCONVULSIVE THERAPY (ECT) CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, section 5.2.8, authorizes coverage of Electroconvulsive Therapy (ECT) when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is at least 13 years old or meets the state-specific age requirement if higher than 13
- ☐ Is currently experiencing at least one of the following:
  - ☐ Treatment-Resistant Depression (i.e., failure to respond to two adequate trials of antidepressants in different categories, e.g., SSRI, SNRI, NDRI, etc.)
  - ☐ Mania
  - ☐ Psychosis
  - ☐ Catatonia
  - ☐ Other psychiatric conditions limiting adequate nutrition and hydration
- ☐ Has failed to respond to clinically reasonable trials of other evidence-based treatments

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

ESKETAMINE (SPRAVATO™) CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, etc.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, authorizes coverage of esketamine treatment when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is 18 years of age or older
- ☐ Will be treated by a provider enrolled in the FDA's Spravato™ Risk Evaluation and Mitigation Strategy (REMS) program
- ☐ Has a documented diagnosis for which esketamine has received FDA approval for use:
  - ☐ Treatment-Resistant Depression (i.e., failure to respond to two adequate trials of antidepressants in different categories, e.g., SSRI, SNRI, NDRI, etc.)
  - ☐ Major Depressive Disorder with suicidal ideation or behavior
- ☐ Does not have any of the following contraindications:
  - Current or history of blood vessel aneurysms
  - Current or history of Arteriovenous (AV) malformations
  - History of Intracerebral hemorrhage
  - Current Pregnancy

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	

TRANSCRANIAL MAGNETIC STIMULATION (TMS) CHECKLIST

Please complete the form below and save this page as a PDF. Then, submit it along with supporting documents that show medical necessity, such as psychiatric assessment, recent progress notes, and any other relevant information.

TRICARE Policy Manual (TPM) Chapter 7, Section 3.7, authorizes coverage of TMS when it is medically necessary and meets the following *minimum* criteria:

THE PATIENT:

- ☐ Is at least 15 years old or meets the state-specific age requirement if higher than 15
- ☐ Has a documented diagnosis of active Treatment-Resistant Depression (i.e., failure to respond to two adequate trials of antidepressants in different categories, e.g., SSRI, SNRI, NDRI, etc.)
- ☐ Has failed to respond to a properly conducted trial of evidence-based psychotherapy
- ☐ Does not have any of the following contraindications:
  - Implanted ferromagnetic material
  - History of seizures
  - Cardiac pacemaker
  - Implanted defibrillator
  - Implanted medical pump
  - Severe cardiovascular disease

Additional information:

FORM SUBMITTED BY:

Name:	Date (MM/DD/YYYY):
Role/Position:	