

CUSTODIAL CARE TRANSITIONAL POLICY (CCTP)

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AUTHORITY: [32 CFR 199.4\(e\)\(12\)](#)

I. BACKGROUND

Section 701(c) of the National Defense Authorization Act (NDAA) for Fiscal Year 2002 changed the definition of custodial care. Effective December 28, 2001, custodial care is no longer defined by the condition of the patient but by the type of services being rendered. This transitional policy provides TRICARE coverage of medically necessary skilled services to eligible beneficiaries and will remain in effect until implementation of the **skilled nursing facility or the home health care benefits** under Section 701(a) of the NDAA for Fiscal Year 2002, and the **Skilled Nursing Facility Prospective Payment System (SNF PPS) or the Home Health Agency Prospective Payment System (HHA PPS)** under Section 707 of the NDAA for Fiscal Year 2002.

II. DEFINITIONS

A. Custodial care. Effective December 28, 2001, the term “custodial care” means treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that – (A) can be rendered safely and reasonably by a person who is not medically skilled; or (B) is or are designed mainly to help the patient with the activities of daily living.

B. Activities of daily living. Care that consists of providing food (including special diets), clothing, and shelter; personal hygiene services; observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision. Activities of daily living may also be referred to as “essentials of daily living”.

III. POLICY

Benefits are payable when a beneficiary meets the custodial care definition in [Chapter 7, Section 13.1](#) and requires medically necessary skilled services in addition to those currently allowed by that policy, that is, one hour of nursing care per day and one physician visit per month related to the condition for which the patient is receiving custodial care.

IV. POLICY CONSIDERATIONS

A. For a beneficiary who meets the custodial care definition in [Chapter 7, Section 13.1](#), the Managed Care Support Contractor is “at-risk” for the services and supplies allowed by that policy.

B. For a beneficiary who meets the custodial care definition in [Chapter 7, Section 13.1](#), and who requires medically necessary skilled services beyond what is allowed by that policy, “pass-through” funds may be used upon approval by the TRICARE Chief Medical Officer (CMO) or designee.

C. To obtain approval for the use of “pass-through” funds, the Managed Care Support Contractor shall submit a “custodial care determination letter” to the TRICARE CMO or designee. The letter may be sent by facsimile (fax) to (703) 681-1242.

D. The custodial care determination letter must include a concurrence line for the TRICARE CMO or designee and demonstrate that the beneficiary

1. is disabled mentally or physically and that such disability(ies) is(are) expected to continue and be prolonged;
2. requires a protected, monitored or controlled environment;
3. requires assistance to support the activities of daily living, and
4. is not undergoing a plan of care which includes specific medical, surgical or psychiatric treatment that will reduce the disability(ies) to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

NOTE: A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

E. Upon completion of his/her review, the TRICARE CMO or designee will return the custodial care determination letter to the Managed Care Support Contractor, generally by fax within one (1) business day of receipt of the letter, indicating concurrence or non-concurrence with the Managed Care Support Contractor’s determination that the beneficiary meets the custodial care definition in [Chapter 7, Section 13.1](#).

F. The TRICARE CMO’s or designee’s concurrence with the custodial care determination constitutes approval for the Managed Care Support Contractor to process the claims and bill the TRICARE program for the additional medically necessary skilled services for that beneficiary.

NOTE: The purpose of the custodial care determination letter is only to obtain the concurrence of the TRICARE Chief Medical Officer, or designee, that the beneficiary meets the definition of custodial care as stated in [Chapter 7, Section 13.1](#). The Managed Care Support Contractor remains responsible for determining the medical necessity of the requested skilled services.

G. The TRICARE CMO's or designee's decision regarding the custodial care determination is transferable between Health Service Regions, that is, the "receiving" Managed Care Support Contractor will accept the current decision of the TRICARE CMO or designee and proceed to process claims accordingly.

H. The beneficiary will not be issued a custodial care determination.

I. The CMO's or designee's decision not to concur with the Managed Care Support Contractor's determination that the beneficiary meets the definition of custodial care in [Chapter 7, Section 13.1](#) may not be appealed.

J. When the TRICARE CMO or designee does not concur with the custodial care determination, the Managed Care Support Contractor is responsible for all medically necessary services from current contract dollars.

K. Claims Processing.

1. Claims for skilled services and physicians services currently covered by the contractor's "at-risk" funds will be processed as batch claims using the custodial care special processing code "CT V".

2. Claims for the additional medically necessary skilled services will be processed on a voucher with the custodial care special processing code "CT W" and paid with "pass-through" funds.

3. Claims for those CCTP beneficiaries who are admitted to a Skilled Nursing Facility on or after the Skilled Nursing Facility Prospective Payment System (SNF PPS) implementation date (August 1, 2003) will be reimbursed under the SNF PPS applying the new SNF benefit criteria subject to the requirements in the TRICARE Reimbursement Manual, [Chapter 8, Section 2](#). CCTP beneficiaries who receive care in their homes will continue to have their claims reimbursed under CCTP until the implementation of Home Health Agency Prospective Payment System.

L. Appeal rights will be offered to the beneficiary for any denied skilled service.

V. EXCLUSIONS

Beneficiaries who were receiving benefits under the ICMP-PEC as of December 27, 2001, and those grandfathered under the former home health care/case management demonstration project will continue to receive those services as grandfathered members of those programs, and will not be considered for the Custodial Care Transitional Policy.

VI. EFFECTIVE DATE December 28, 2001.

