CHAPTER 9
SECTION 15.1

ECHO HOME HEALTH CARE (EHHC)

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I. CPT[1] PROCEDURE CODES

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III. DESCRIPTION

The ECHO Home Health Care (EHHC) benefit provides medically necessary skilled services to eligible homebound beneficiaries whose needs exceed the limits of the Home Health Agency-Prospective Payment System (HHA-PPS) as described in the TRICARE Reimbursement Manual (TRM). Also included in the EHHC is respite care under certain circumstances.

IV. BACKGROUND

Section 701 of the National Defense Authorization Act for Fiscal Year 2002 (NDAA-FY02; Public Law 107-107; December 28, 2001) added a new Section 10 U.S.C. 1074j that establishes a comprehensive, part-time or intermittent home health care benefit to be provided in the manner and under the conditions described in Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)). Consequently, the Department has adopted Medicare's benefit structure and prospective payment system for reimbursement of part-time or intermittent home health services. Known as the TRICARE HHA-PPS, this benefit limits coverage of home health services to a maximum of 35 hours per week and does not provide respite care services. NDAA-FY02 also established the program of "Extended Benefits for Disabled Beneficiaries" [10 U.S.C. 1079(d-f)]. This program of "comprehensive home health care supplies and services" includes cost effective and medically appropriate services other than part-time or intermittent services. As a result, eligible family members should be able to reside at home rather than be confined to institutional facilities.

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V. POLICY

A. Eligibility.

1. TRICARE beneficiaries who are registered in the ECHO are eligible to receive ECHO Home Health (EHHC) when:

a. The beneficiary physically resides within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam; and

b. The beneficiary is homebound as defined in paragraph VI.A.1.; and

c. The beneficiary requires medically necessary skilled services beyond the level of coverage provided by the TRICARE HHA-PPS; and/or

d. The beneficiary requires frequent interventions that are normally provided by the beneficiary's primary caregiver(s); and

e. The beneficiary is case-managed and the required services are specified in a physician-certified plan of care.

2. To avoid delaying receipt of EHHC services while completing the ECHO registration process, in particular awaiting completion of enrollment in the Exceptional Family Member Program (EFMP) of the sponsor's service, otherwise ECHO-eligible beneficiaries may be granted provisional eligibility for a period of not more than 90 days. Examples of beneficiaries who may be granted such status include, but are not limited to:

a. Newborns;

b. Recently adopted family members;

c. Newly ascended active duty service members having a family member with an ECHO qualifying condition; and

d. Other family members, who, because of injury, illness, or trauma become ECHO-eligible.

3. Upon completion of the ECHO registration process, the provisional status will be converted to permanent and subject to all other applicable requirements and made retroactive to the date of the request for EHHC or respite care services.

4. If it is determined that the beneficiary is not eligible for the ECHO, the provisional status will be terminated; authorization and government liability for ECHO benefits will also terminate at that time. The government will not recoup claims paid for ECHO benefits provided during the provisional period.

B. EHHC. The following are covered when provided in the beneficiary's home by participating TRICARE-authorized HHAs.

1. Medically necessary services:

a. Skilled nursing care provided by a registered nurse;

b. Skilled nursing care provided by a licensed or vocational nurse under the direct supervision of a registered nurse;

c. Services provided by a home health aide under the direct supervision of a registered nurse;

d. Physical therapy, occupational therapy, and speech-language pathology services;

e. Medical social services under the direction of a physician;

f. Teaching and training activities; and

g. Medical supplies.

2. Respite care services:

a. EHHC-eligible beneficiaries who require frequent interventions (as defined in paragraph VI.A.4.) may receive eight hours of respite care services on 5 days per calendar week.

b. The respite care services will relieve the primary caregiver(s) of the responsibility to provide such services in order to allow them the opportunity to rest or sleep.

c. This respite care benefit can not be provided in addition to the 16 hours per month respite care benefit discussed in Chapter 9, Section 12.1.

d. The respite care periods can be provided on consecutive days, but can not run consecutively. For example, a period from 4:00 p.m. to 12 midnight on one day can not be immediately followed by a period from 12 midnight to 8:00 a.m. the next day.

e. Authorized but unused respite care periods, or portions thereof, can not be saved or accumulated for future use.

VI. POLICY CONSIDERATIONS

A. Definitions. The following definitions are applicable to the EHHC benefit.

1. Homebound. For the purpose of the EHHC, "homebound" means a beneficiary's condition is such that there exists a normal inability to leave home and consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment or in an adult day care program certified by a state, or accredited to furnish adult day care services in the state, shall not disqualify an individual from being considered to be confined to his home.

Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For the purposes of the preceding sentence, any absence for purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. In addition to the above, absences, whether regular or infrequent, from the beneficiary's primary residence for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

a. Although this definition indicates that a beneficiary's participation in a day care center or educational program does not disqualify them from EHHC or respite care, it does not indicate that such services will be paid for if provided outside the beneficiary's primary residence. EHHC services and respite care services will be cost-shared by TRICARE only when such services are provided in the beneficiary's primary residence.

b. HHAs are responsible for demonstrating that the adult day care center is licensed or certified/accredited as part of determining whether the patient is homebound for purposes of EHHC eligibility. Examples of information that can demonstrate licensure or certification/accreditation include: the license or certificate of accreditation of the adult day care center; the effective date of the license or certificate of accreditation; and the name of the authority responsible for the license or certificate of accreditation of the adult day care center.

2. Beneficiary's Primary Residence. A beneficiary's primary residence is wherever he/she makes his/her home, that is, generally takes meals and sleeps. This may be the beneficiary's own dwelling, or a relative's or non-relative's home.

a. For the purpose of EHHC, institutions such as Skilled Nursing Facilities (SNFs), hospitals and other acute care facilities, intermediate care facilities, assisted living facilities, and nursing facilities operated under Title XIX of the Social Security Act (Medicaid), are not considered as the beneficiary's primary residence.

b. If a beneficiary is in an institution or distinct part of an institution as identified above, the beneficiary is not considered homebound and therefore is not entitled to the ECHO Home Health Care benefit.

3. Beneficiary's Qualifying Condition. Moderate or severe mental retardation, serious physical disability, or extraordinary physical or psychological condition. See Chapter 9, Sections 2.2 through 2.4.

4. Frequent Interventions. For a homebound ECHO-eligible beneficiary, frequent interventions means services, as included in the beneficiary's plan of care, which are required more than two times during the 8 hour period the primary caregiver(s) would normally be sleeping. These services consist of skilled services that can be performed safely and effectively by the average non-medical primary caregiver(s) without direct supervision of a health care provider after such individual(s) has been trained by appropriate medical personnel.

5. Participating TRICARE-authorized Home Health Agency (HHA). A HHA that meets the requirements of 32 CFR 199.6(b)(4)(xv) and has a valid participation agreement in effect at the time the EHHC services are rendered.

B. Authorization. All EHHC services must be included in the beneficiary's plan of care and authorized by the Managed Care Support Contractor (MCSC) or Director, TRICARE Area Office prior to those services being rendered.

C. Beneficiary Assessment.

1. For the purpose of the EHHC benefit, the beneficiary's attending physician or primary care manager is responsible for determining the required medically necessary skilled services. This includes, but is not limited to the scope, frequency and duration of such services, and is the basis for the plan of care.

2. The EHHC benefit is not subject to the HHA-PPS, therefore, the MCSCs are not required to use the Outcome and Assessment Information Set (OASIS) nor the CMS Form 485 when developing the plan of care.

D. Plan of Care.

1. Scope. A multi-discipline oriented plan of care will be developed by the beneficiary's attending physician, or designee, together with the assistance of the HHA. At a minimum, the plan must include:

a. All pertinent diagnoses and qualifying condition(s), including the beneficiary's mental status;

b. The type, frequency, and duration of services and supplies, including any medically necessary treatments;

c. Assessment of the beneficiary's functional limitations and activities permitted;

d. The potential for rehabilitation or prevention of deterioration of the beneficiary's condition;

e. Nutritional requirements, including but not limited to enteral and parenteral nutritional therapy and other special dietary requirements and restrictions;

f. Dosage and administration of all medications;

g. Safety measures to protect the beneficiary and the provider against injury;

h. Instructions for timely discharge or completion of a treatment and referral for other skilled services;

i. Those services to be taught to the primary caregiver(s) as discussed in paragraph VI.A.4.

j. The professional level of provider expected to render the specified services;

k. Although paid under the TRICARE Basic Program and not included in the EHHC fiscal year benefit cap, the following shall also be included in the beneficiary's plan of care:

(1) Required durable medical equipment to be rented or purchased;

(2) FDA-approved injectable drugs for osteoporosis;

(3) Pneumoccal pneumonia, influenza virus and hepatitis B vaccines;

(4) Oral cancer drugs and antiemetics;

(5) Orthotics and prosthetics;

(6) Ambulance services operated by the HHA;

(7) Enteral and parenteral supplies and equipment; and

(8) Other drugs and biologicals administered by other than oral method.

l. Although paid under the ECHO, the plan of care shall also include required durable equipment to be rented or purchased.

m. Any other information the beneficiary's attending physician or primary care manager, the MCSC case manager, and the HHA believe necessary in order to provide the beneficiary with the appropriate level of services.

2. Plan Certification. Upon completion, the following certifications will be provided by signature on the plan of care:

a. The beneficiary's attending physician or primary care manager will certify that:

(1) The beneficiary is homebound; and

(2) The beneficiary requires medically necessary skilled services that exceed the HHA-PPS under the TRICARE Basic Program; and/or

(3) The beneficiary requires frequent interventions, as defined in paragraph VI.A.4., such that respite care services are needed in order to allow the primary caregiver(s) the opportunity to rest or sleep; and

(4) The services are allowable TRICARE benefits through the ECHO.

b. The HHA will certify that:

(1) The agency has an agreement to participate in the TRICARE program and will continue such agreement for the duration of the plan; and

(2) The agency agrees with the plan of care; and

(3) The agency has available, or will obtain, the appropriate professional level of providers who will render the services indicated in the plan of care; and

(4) Reimbursement for services provided by the HHA or its designee(s) will be in accordance with the TRICARE allowable amount or the rate(s) negotiated with the MCSC.

c. The MCSC will certify that:

(1) The MCSC accepts the plan of care, and

(2) The services are authorized effective on the date of such certification.

NOTE: If the MCSC does not accept the plan of care, the beneficiary or provider, as appropriate, will be afforded appeal rights in accordance with the TRICARE Operations Manual (TOM), Chapter 13.

3. Responsible Party. The MCSC has overall responsibility for development and review of the plan of care in accordance with the requirement that ECHO beneficiaries who need home health care are case-managed.

4. Reassessment.

a. The plan of care will be reviewed for appropriateness whenever the MCSC is informed that the condition of the beneficiary has changed or there is otherwise a need to update the plan, but in all cases the beneficiary will be reassessed and the plan reviewed and updated at least every 90 days.

b. If at any time the MCSC determines that the required level of home health care services falls within the allowable level through the HHA-PPS, the beneficiary will be referred to receive appropriate services under the HHA-PPS.

5. Plan of Care Revisions.

a. Revisions to the plan of care that result from reassessment in accordance with paragraph VI.D.4., will be signed by the attending physician and concurred with by the beneficiary's case manager. As with the initial plan of care, the case-manager's concurrence will constitute acceptance of the revision by the MCSC and authorization for those services.

b. When the supervising registered nurse, or physical therapist, occupational therapist, or speech-language pathologist has reason to believe that services beyond those

included in the plan of care are required, they are to immediately inform the beneficiary's case manager.

(1) Any increase in the frequency of services or addition of new services during an authorization period must be authorized by a physician by way of a written or oral order prior to the provision of the increased or additional services.

(2) If the beneficiary's attending physician agrees, the case manager will revise the plan of care, obtain the physician's and HHA's signatures, provide the required MCSC concurrence and authorize the additional services.

(3) Records of telephone conversations and documents bearing physician orders and signatures that are/have been transmitted by facsimile will be maintained as supporting documentation to the plan of care and maintained by the case manager.

6. For the sake of timeliness, the steps under paragraph VI.D.5. may be accomplished by telephone and/or by facsimile machine.

7. Facsimile Signatures. The plan of care or oral order(s) may be transmitted by facsimile machine. Original signatures on the plan of care may be maintained by either the HHA or the MCSC.

8. Alternative Signatures. HHAs that maintain patient records by computer rather than hard copy may use electronic signatures.

a. However, all such entries must be appropriately authenticated and dated.

b. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry.

c. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

E. Reasonable and Medically Necessary Care. When provided in accordance with the plan of care, the following are considered reasonable and medically necessary care.

1. Skilled Nursing Services. Application of professional nursing services and skills by an RN, LPN, or LVN, that are required to be performed at the direction of or under the general supervision of a TRICARE-authorized physician to ensure the safety of the patient and achieve management of the beneficiary's qualifying condition in accordance with accepted standards of practice.

a. A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical or vocational nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone, for example intravenous and intramuscular injections or insertion of catheters, if reasonable and medically necessary,

would be covered on that basis. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse.

b. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a nurse. Where a service can be safely and effectively performed or administered by the average nonmedical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

c. A service, which by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. Where the patient needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a nurse would be reasonable and necessary for the management of the beneficiary's qualifying condition.

d. The skilled nursing services must be in accordance with accepted standards of medical and nursing practice and consistent with the beneficiary's qualifying and overall medical condition.

e. The beneficiary's qualifying condition should never be the sole factor in deciding that an EHHC service the beneficiary needs is either skilled or not skilled.

f. The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the qualifying condition of the patient when the services were ordered and what was, at the time, reasonably expected to be appropriate management of the beneficiary's qualifying condition throughout the certification period.

g. Skilled nursing visits for management and evaluation of the patient's plan of care are reasonable and medically necessary where underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose.

h. Administration of Medications. The services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the management of the qualifying condition.

(1) Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively.

(2) Vitamin B-12 Injections. Vitamin B-12 injections are considered specific therapy only for the following conditions:

(a) Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

(b) Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome;

(c) Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism;

(d) For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment.

(3) Insulin Injection. Insulin is customarily self-injected by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

(4) Oral Medications. The administration of oral medications by a nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the patient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The following are some examples of situations in which the administration of oral medications by a nurse would be considered reasonable or necessary skilled nursing care:

(a) Example 1. A beneficiary with arteriosclerotic heart failure, in addition to their qualifying condition, requires observation by skilled nursing personnel for signs of decompensation or adverse effects from prescribed medication. Skilled observation is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the beneficiary's condition is stabilized.

(b) Example 2. A beneficiary with glaucoma and a cardiac condition, in addition to their qualifying condition, has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmias. Skilled observation and monitoring of the drug actions is reasonable and necessary until the beneficiary's condition is stabilized.

(5) Eye Drops and Topical Ointments. The administration of eye drops and topical ointments does not require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service.

(6) Tube Feeding. Nasogastric tube, and percutaneous tube feeding (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization

and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services. However, the nutritional therapy products delivered by tube feeding will not be subject to the fiscal year EHHC benefit cap, but will be reimbursed under the TRICARE Basic Program.

(7) Nasopharyngeal and Tracheostomy Aspiration. Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's illness or injury, would be covered as skilled nursing services.

(8) Catheters. Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter and in selected patients, urethral catheters, are considered be skilled nursing services.

(9) Wound Care. Care of wounds (including, but not limited to ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service.

(10) Ostomy Care. Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications.

(11) Heart Treatments. Heart treatments that have been specifically ordered by a physician as part of active treatment of an illness or injury and require observation by a licensed nurse to adequately evaluate the patient's progress would be considered skilled nursing services.

(12) Medical Gases. Initial phases of a regimen involving the administration of medical gases that are necessary to the treatment of the patient's illness or injury, would require skilled nursing care for skilled observation and evaluation of the patient's reaction to the gases, and to teach the patient and family when and how to properly manage the administration of the gases.

(13) Rehabilitation Nursing. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services.

(14) Venipuncture. Venipuncture, when the collection of the specimen is necessary to the diagnosis and treatment of the patient's illness or injury and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment in a SNF, is considered to be a skilled nursing service.

i. Teaching and Training Activities.

(1) Teaching and training activities that require skilled nursing personnel to teach the beneficiary, the beneficiary's family or caregiver(s) how to manage the beneficiary's qualifying condition constitute skilled nursing services.

(2) When the teaching or training is reasonable and medically necessary to manage the beneficiary's qualifying condition, skilled nursing visits for teaching are covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered.

(3) Teaching and training activities that require the skills of a licensed nurse include, but are not limited to the following:

(a) Self-administration of an injectable medication or a complex range of medications;

(b) Diabetes management including how to prepare and administer insulin injections, prepare and follow a diabetic diet, to observe foot-care precautions, and to watch for and understand signs of hyperglycemia and hypoglycemia;

(c) Self-administration of medical gases;

(d) Wound care when the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

(e) Care for a recent ostomy or where reinforcement of ostomy care is needed;

(f) Self-catheterization;

(g) Self-administration of gastrostomy or enteral feedings;

(h) Care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

(i) Bowel or bladder training when bowel or bladder dysfunction exists;

(j) How to perform the activities of daily living when the patient or caregiver(s) must use special techniques and adaptive devices due to a loss of function;

(k) Transfer techniques, for example from bed to chair, that are needed for safe transfer;

(l) Proper body alignment and positioning, and timing techniques of a bed-bound patient;

(m) Ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

(n) Prosthesis care and gait training;

(o) Use and care of braces, splints and orthotics and associated skin care;

(p) Proper care and application of any specialized dressings or skin treatments, for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration from radiation treatment;

(q) Preparation and maintenance of a therapeutic (nutritional therapy) diet; and

(r) Proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

2. Skilled Therapy Services.

a. General Principles.

(1) The services of an occupational therapist, a physical therapist, and a speech-language pathologist are skilled therapy services if the inherent complexity of the service is such that it can be performed safely and effectively only by a skilled therapist.

(2) The skilled services must be reasonable and necessary for the management of the beneficiary's qualifying condition or for the restoration or maintenance of function affected by the beneficiary's qualifying condition. To be considered reasonable and necessary the services must be:

(a) Consistent with the nature and severity of the disabling effects of the beneficiary's qualifying condition, including the requirement that the type, frequency and duration of the services must be reasonable; and

(b) Reasonable in regards to the type, frequency, and duration of the services; and

(c) Considered to be specific, safe, and effective management of the beneficiary's qualifying condition; or

(d) Necessary for the establishment of a safe and effective maintenance program.

NOTE: Services involving activities for the general welfare of the beneficiary, for example, general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Those services can be performed by non-skilled individuals without the supervision of a therapist.

(3) The evaluation, development, and implementation of the beneficiary's plan of care constitute skilled therapy services when the beneficiary's condition requires the involvement of a skilled therapist to manage the beneficiary's qualifying condition and ensure medical safety.

(4) The services of a skilled therapist when needed to manage and periodically reevaluate the appropriateness of a maintenance program are covered, even if the therapist's services are not needed to carry out the activities performed as a part of the maintenance program.

(5) While the beneficiary's qualifying condition is a valid factor in deciding if skilled therapy services are needed, the qualifying condition should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to safely manage the beneficiary's qualifying condition or whether the services can be provided by non-skilled personnel.

(6) A service that is ordinarily considered non-skilled could be considered a skilled service in cases where there is clear documentation that, because of complications or possible complications, or the requirement to manage the beneficiary's qualifying condition, skilled rehabilitation personnel are required to perform or supervise the service or to observe the beneficiary. However, the importance of a particular service to a beneficiary or the frequency with which it must be performed does not, by itself, make a non-skilled service into a skilled service.

(7) Services of skilled therapists for the purpose of teaching the patient or the patient's family or caregivers necessary techniques, exercises or precautions are covered to the extent that they are reasonable and necessary to manage the beneficiary's qualifying condition. However, time spent by skilled therapists in a beneficiary's home for the purpose of training other HHA staff, home health aides for example, is not billable since the agency is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost for such time and services is an administrative cost to the agency.

b. Application of the General Principles to Occupational Therapy Services.

(1) Assessment. The skills of an occupational therapist to assess and reassess a beneficiary's rehabilitation or maintenance of function needs and potential, or to develop and/or implement an occupational therapy program, are covered when they are reasonable and necessary because of the patient's condition.

(2) Planning, Implementing and Supervision of Therapeutic Programs. The planning, implementing and supervision of therapeutic programs including, but not limited to those listed below, are skilled occupational therapy services, and if reasonable and necessary to the management of the beneficiary's qualifying condition, are covered. The MCSC's medical review staff will be responsible for determining the reasonableness and necessity of therapeutic programs not listed under this paragraph.

(a) Selecting and teaching task oriented therapeutic activities designed to restore or maintain current level of physical function.

(b) Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

(c) Teaching compensatory techniques to improve the level of independence in the activities of daily living.

(d) The designing, fabricating and fitting of orthotics and allowable self-help devices.

(e) Vocational and prevocational assessment and training that is directed toward the restoration or maintenance of function with respect to the activities of daily living lost due to a qualifying condition are covered.

c. Application of the General Principles to Physical Therapy Services.

(1) Assessment. The skills of a physical therapist to assess and periodically reassess a patient's needs, or to develop/implement a physical therapy program, are covered when reasonable and necessary because of the beneficiary's qualifying condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance or functional ability.

(2) Therapeutic Exercises. Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

(3) Gait Training. Gait evaluation and training, which require the skills of a qualified physical therapist, furnished to a beneficiary whose ability to walk has been impaired by the qualifying condition constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to either improve the beneficiary's ability to walk or maintain current level of ability to walk.

(a) Repetitive exercises to improve gait or to maintain strength and endurance and assistive walking are appropriately provided by non-skilled persons and ordinarily do not require the skills of a physical therapist.

(b) However, where such services are performed by a physical therapist as part of the initial design and establishment of a safe and effective maintenance program, the services would, to the extent that they are reasonable and necessary, be covered.

(4) Range of Motion. Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

(a) Range of motion exercises constitute skilled physical therapy only if they are part of the management of the qualifying condition that results in the loss of restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored).

(b) Range of motion exercises unrelated to the restoration of a specific loss of function often may be provided safely and effectively by non-skilled individuals. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by non-skilled persons do not constitute physical therapy.

(c) However, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, then the services would be covered.

(5) Maintenance Therapy. Where repetitive services that are required to maintain function involve the use of complex and sophisticated procedures, the judgement and skill of a physical therapist might be required for the safe and effective rendering of such services. If the judgement and skill of a physical therapist is required to safely and effectively render such services, they would be covered as physical therapy services. While a beneficiary is under a restorative physical therapy program, the physical therapist should regularly reevaluate the beneficiary's condition and adjust any exercise program the beneficiary is expected to carry out him/herself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session), the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

(6) Ultrasound, Shortwave, and Microwave Diathermy Treatments. These treatments must always be performed by or under the supervision of a qualified physical therapist and are considered skilled therapy.

(7) Hot Packs, Infrared Treatments, Paraffin Baths and Whirlpool Baths. Heat treatments and baths of this type ordinarily do not require the skills of qualified physical therapist. However, the skills, knowledge and judgement of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case; e.g., where the beneficiary's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complication.

d. Application of the General Principles to Speech-Language Pathology Services.

(1) The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders) and rehabilitation potential. Reevaluation would only be considered reasonable and necessary if the beneficiary exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical condition that previously contraindicated speech-language pathology services. Where a beneficiary is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy.

(2) The services of a speech-language pathologist are covered if they are needed as a result of the qualifying condition and are directed towards specific speech/voice production.

(3) Speech-language pathology is covered when the service can only be provided by a speech-language pathologist and where it is reasonably expected that the service will materially improve the patient's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurable at a higher level of attainment than that attained prior to the initiation of the services. There must be an anticipated improvement in the patient's communicative ability in order for coverage to be extended under the home health benefit.

(4) The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cuing that directs a patient toward speech-language communication goals in the plan of care would be covered speech-language pathology.

(5) The services of a speech-language pathologist to train the beneficiary, the beneficiary's family or other caregivers to augment the speech-language services, or to establish an effective maintenance program are covered speech-language pathology services.

(6) The services of a speech-language pathologist to assist beneficiaries with aphasia resulting from the qualifying condition are covered.

(7) The services of a speech-language pathologist to assist beneficiaries with voice disorders resulting from the qualifying condition to develop proper control of the vocal and respiratory systems for correct voice production are covered.

3. Home Health Aide Services.

a. Home health aide services are covered when

(1) The beneficiary meets the eligibility requirements in paragraph V.A.;

(2) The services are medically necessary and reasonable for the management of the beneficiary's qualifying condition;

(3) The services are included in the physician-approved plan of care; and

(4) The services meet the definition of home health aide services.

b. The reason for the visits by the home health aide must be to provide hands-on personal care of the beneficiary or services needed to maintain the beneficiary's health or to facilitate management of the beneficiary's ECHO-qualifying condition.

c. Home health aide services may include, but are not limited to:

(1) Personal Care. Personal care means:

(a) Bathing, dressing, grooming, caring for hair, nails and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care and ear care;

(b) Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition), routine catheter care and routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers;

(c) Simple dressing changes that do not require the skills of a licensed nurse;

(d) Assistance with medications which are ordinarily self-administered and do not require the skills of a licensed nurse to be provided safely and effectively;

(e) Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed, such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services; and

(f) Routine care of prosthetic and orthotic devices.

(2) Other Services. When a home health aide visits a beneficiary to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service, for example light cleaning, preparation of a meal, taking out the trash, shopping, etc. However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

4. Medical Social Services. Medical social services that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services when the beneficiary meets the eligibility requirements in paragraph V.A.; and

a. The services of these professionals are necessary to resolve social or emotional problems that are, or are expected to be, an impediment to the effective management of the beneficiary's qualifying condition; and

b. The plan of care indicates how the required services necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker in order to be performed safely and effectively.

c. When both of these requirements for coverage are met, services of these professionals that may be covered include, but are not limited to:

(1) Assessment of the social and emotional factors related to the beneficiary's qualifying condition, need for care, response to care and adjustment to care;

(2) Assessment of the relationship of the beneficiary's medical and nursing requirements to the beneficiary's home situation, financial resources and availability of community resources;

(3) Appropriate action to obtain available community resources to assist in resolving the beneficiary's patient's problem;

(4) Counseling services that are required by the beneficiary; and

(5) Medical social services furnished to the patient's family member(s) or caregiver(s) on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective management of the beneficiary's qualifying condition or to his or her rate of recovery, are covered. To be considered "clear and direct," the behavior or actions of the family member(s) or caregiver(s) must plainly obstruct, contravene, or prevent appropriate management of the beneficiary's qualifying condition. Medical social services to address general problems that do not clearly and directly impede management of the beneficiary's qualifying condition, as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

(6) Participating in the development of the plan of care, preparing clinical and progress notes, participating in planning and in-service programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the HHA.

5. Medical Supplies.

a. Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential to enabling HHA personnel to carry out effectively the care the physician has ordered for the management of the beneficiary's qualifying condition.

b. Routine supplies are generally consumable, that is, they can not withstand prolonged or repeated use, and are customarily used during the course of home health care visits. They are generally not designated for a specific patient.

c. Non-routine supplies, which may or may not be consumable, are those supplies that are specifically ordered by the physician and are essential in order for HHA personnel to provide the services indicated in the plan of care.

(1) Non-routine medical supplies will be indicated in the beneficiary's plan of care with specific justification that demonstrates why the supply item(s) is needed and why it is not considered a routine supply item.

(2) Except as otherwise provided in paragraph VI.G.10., medical supplies will not be billed separately, that is, the cost for such will be included in the allowable charge or the hourly rate negotiated between the MCSC and the HHA.

d. Items that generally serve a routine hygienic purpose, for example soaps and shampoos, and items that generally serve as skin conditioners such as baby lotion, baby oil, skin softeners, powders, and other skin care lotions, are not considered medical supplies unless the particular item is recognized as serving a specific purpose in the physician's prescribed management of the beneficiary's qualifying condition.

e. Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the beneficiary or other caregiver. These items must be part of the plan of care in which the home health staff are actively involved. For example, in the case of a beneficiary who requires a nutritional therapy enteral or parenteral feeding when HHA personnel are not present, it would be appropriate for the agency to leave reasonable quantities of the nutritional therapy product in the beneficiary's home for administration by other caregivers. Items such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

6. Durable Equipment. As defined in 32 CFR 199.2, durable equipment is a device or apparatus that does not qualify as Durable Medical Equipment (DME) under the Basic Program but which is essential to the efficient arrest or reduction of functional loss resulting from, or the disabling effects of, the beneficiary's qualifying condition as discussed in Chapter 9, Sections 2.2 through 2.4. Examples of durable equipment are special computer peripheral devices (keyboard, mouse, etc.) or software that makes a computer functional to an ECHO beneficiary with a qualifying condition that would otherwise limit or prohibit the beneficiary's ability to use the computer; or a electrical/mechanical lifting device that raises an ECHO beneficiary in a wheelchair from ground level to first floor level of the beneficiary's residence.

7. Durable Medical Equipment (DME). DME, although included in the plan of care and provided by a HHA, is not part of the EHHC benefit; it will be cost-shared only through the TRICARE Basic Program.

F. Authorized Providers.

1. All EHHC and respite care services will be provided only by TRICARE-authorized HHAs who have in effect at the time of services a valid agreement to participate in the TRICARE program;

a. In order to receive payment for home health care services provided in accordance with this issuance, HHAs must be Medicare or Medicaid certified and meet all applicable Medicare or Medicaid conditions of participation.

b. HHAs for which Medicare or Medicaid certification is not available due to the specialized categories of individuals they serve, for example, individuals that are under the age of 18 or who are receiving maternity care, must meet the qualifying conditions for corporate services provider status as specified in Chapter 11, Section 12.1.

2. HHAs, whether or not they are Medicare or Medicaid certified, will be responsible for assuring that all individuals rendering EHHC services and respite care services meet all applicable qualification standards. The MCSCs are not responsible for certification of individuals employed by or contracted with a HHA.

3. Reimbursement for all EHHC services provided by Medicare or Medicaid certified and non-Medicare or non-Medicaid certified HHAs will be as discussed in paragraph VI.G. and H.

G. Claims

1. Billing. HHAs will use itemized billing for EHHC services, including those items that will be cost-shared under the TRICARE Basic Program, that are identified on the beneficiary's plan of care

2. Primary Agency. When necessary, multiple HHAs may be involved in providing the services indicated in the beneficiary's plan of care. When such is the case, the MCSC will designate one such agency as the Primary Agency. In addition to being responsible for providing the services in the plan, the primary agency is also responsible for:

a. Negotiating the reimbursement rate with the MCSC having jurisdiction where the beneficiary lives;

b. Arranging for the services to be provided by other HHAs;

c. Insuring the qualifications of the other HHAs;

d. Insuring that services provided by other HHAs are in accordance with the plan of care; and

e. Reimbursing the other HHAs that provide services.

3. The MCSCs will deny claims from other than the primary agency for services and items provided as described herein.

4. The EHHC and respite care benefits will not use the "Requests for Anticipated Payment."

5. All claims for EHHC services or items will be submitted only after such services or items are provided.

6. EHHC and respite care services will be coded using the appropriate procedure codes shown in paragraph I.

7. The EHHC and respite care benefits will operate on the platform of existing TRICARE claims processing systems.

8. Hours of services provided in accordance with the beneficiary's plan of care will become the unit of reimbursement and tracking in the claims processing systems. The EHHC and respite care benefits require that services be recorded in 1 hour increments.

9. HHAs providing EHHC services will submit claims using the CMS 1500, either in paper form or electronic version.

a. Frequency of submitting claims is at the discretion of the MCSC, that is, the HHA may be required by the MCSC to submit claims weekly, monthly, or at such other intervals as the MCSC determines is appropriate.

b. The monthly (or other billing period as specified by the MCSC) claim will indicate the total hours for each type of service, that is, skilled services, skilled therapy services, home health aide services, and medical social services, will be grouped according to the professional level of the individuals providing such services. The totals will be entered on separate lines of the CMS 1500.

10. The following, although required to be included in the plan of care and when provided by the HHA, will be itemized billed separately from the allowed home health care services and will be cost-shared through the TRICARE Basic Program or the ECHO as appropriate. The amount reimbursed for these items do not accrue to the EHHC fiscal year benefit cap established under paragraph VI.H.

a. Rental or purchase of durable equipment and durable medical equipment;

b. FDA approved injectable drugs for osteoporosis;

c. Pneumoccocal pneumonia, influenza virus and hepatitis B vaccines;

d. Oral cancer drugs and antiemetics;

e. Orthotics and prosthetics;

f. Ambulance services operated by the HHA;

g. Enteral and parenteral supplies and equipment; and

h. Other drugs and biologicals administered by other than oral method.

H. Reimbursement. Reimbursement for the services described in this issuance will be made on the basis of allowable charges or negotiated rates between the MCSCs and the HHAs.

1. Benefit cap. Coverage for the EHHC benefit is capped on a fiscal year basis.

2. Basis of the cap. The purpose of the EHHC benefit is to assist eligible beneficiaries in remaining at their primary residence rather than being confined to institutional facilities, such as a SNF or other acute care facility. Therefore, TRICARE has determined that the appropriate EHHC benefit cap is equivalent to what TRICARE would reimburse if the beneficiary was in a SNF.

a. Annually, the MCSCs will calculate the EHHC cap for each beneficiary's area of primary residence as follows:

(1) Obtain the annual notice, published in the Federal Register, of the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System and Consolidated Billing for SNFs--Update for the upcoming fiscal year. (From time to time the update notice may be known by another name but will contain the same information.)

NOTE: Although CMS periodically publishes updates to the SNF rates during any given fiscal year, those will not be used to calculate the EHHC cap. Only the SNF reimbursement rates in effect on October 1 of each year will be used to calculate the EHHC cap for the fiscal year beginning on that date.

(2) From the "Table 6. RUG-53 Case-Mix Adjusted Federal Rates for Urban SNFs by Labor and Non-Labor Component", determine the highest cost RUG-III category;

(3) Multiply the labor component obtained in (2) by the "Table 8. FY 2007 Wage Index for Urban Areas Based on CBSA Labor Market Areas" value corresponding to the beneficiary's location;

(4) Sum the non-labor component from (2) and the adjusted labor component from (3); the result is the beneficiary's EHHC per diem in that location;

(5) Multiply the per diem obtained in (4) by 365 (366 in leap year); the result is the beneficiary's fiscal year cap for EHHC in that location.

(6) For beneficiary's residing in areas not listed in Table 8, use "Table 7. RUG-53 Case-Mix Adjusted Federal Rates for Rural SNFs by Labor and Non-Labor Component" and "Table 9. FY 2007 Wage Index Based on CBSA Labor Market Areas for Rural Areas" and adjust similarly to steps (3) through (5) to determine the EHHC cap for beneficiaries residing in rural areas.

NOTE: See Chapter 9, Addendum A for an example of the EHHC cap based on the FY 2007 rates published in the Federal Register on July 31, 2006 (71 FR 43158).

NOTE: The previous reference to and use of the Benefits Improvement and Protection Act (BIPA) adjustment in this issuance is deleted as of January 1, 2006.

b. Beneficiaries who seek EHHC at any time during the fiscal year will have their cap calculated as above and prorated by month for the remaining portion of that fiscal year.

c. The maximum amount reimbursed in any month for EHHC services is the amount authorized in accordance with the approved plan of care and based on the actual number of hours of home health care provided and billed at the allowable charge or the negotiated rate. In no case will the amount reimbursed for any month of EHHC exceed one-twelfth (1/12) of the annual fiscal year cap established under paragraph VI.H.2.a. and as adjusted for the actual number of days in the month during which the services were provided.

d. Beneficiaries who move will have their cap recalculated to reflect the wage index for their new location. The maximum amount reimbursed in the remaining months of that fiscal year for EHHC services will reflect the re-calculated EHHC cap.

e. The cost for EHHC services does not accrue to the $2,500 maximum monthly Government cost-share indicated in Chapter 9, Section 16.1.

3. The sponsor's cost share for EHHC services will be as indicated in Chapter 9, Section 16.1.

I. Transition to EHHC.

1. Following modification of the MCS contracts that incorporates the ECHO, the MCSCs will identify all active duty family members who are currently using, or have used any benefit of the PFPWD within the 12-month period immediately preceding the contract modification. The MCSCs will also identify those active duty family members who are in SNFs.

2. Not less that 60 days prior to the scheduled implementation of the ECHO, the MCSCs will send the government furnished notification and information brochures to all beneficiaries identified in paragraph VI.I.1. The notification announces the conversion of the PFPWD to the ECHO and the brochure highlights the benefit structure, the requirements, and the primary points of contact to access the ECHO.

3. Beneficiaries in SNFs will be afforded the opportunity to relocate to a more natural setting, such as in the sponsor's home, or other primary residence as defined herein.

4. MCSCs will assist EHHC-eligible beneficiaries with initiating the ECHO registration process and developing and approving the plan of care.

5. Those homebound beneficiaries whose need for skilled services can be appropriately met by the HHA-PPS (TRM, Chapter 12) will be required to access that program for such services.

NOTE: Although it is the intent that eligible beneficiaries complete the registration process and all applicable requirements of this issuance by the date of implementation of the ECHO, it is recognized that certain requirements may not be completed at that time. Therefore, to avoid delaying necessary services, those otherwise ECHO-eligible beneficiaries will be granted provisional eligibility status for a period of not more than 90 days following the date of implementation during which EHHC benefits will be authorized and payable. Beneficiaries failing to complete the ECHO registration process and the requirements of this issuance by the end of that 90 day period will be determined ineligible, at which point authorization and Government liability for all ECHO/EHHC benefits will terminate. The Department will not recoup claims paid for ECHO benefits provided during the provisional period.

6. Following implementation of the ECHO, the MCSCs will make available the Government furnished information brochures to beneficiaries seeking information about or access to the ECHO.

VII. EXCLUSIONS

A. Basic program and the ECHO Respite Care benefit (see Chapter 9, Section 12.1).

B. EHHC services will not be provided outside the beneficiary's primary residence.

C. EHHC respite care services are not available for the purpose of covering primary caregiver(s) absences due to deployment, employment, seeking employment, or to pursue education.

D. EHHC services and supplies can be provided only to the eligible beneficiary, that is, such services will not be provided to or on behalf of other members of the beneficiary's family nor other individuals who reside in or are visiting in the beneficiary's primary residence.

E. EHHC services and supplies are excluded from those who are being provided continuing coverage of home health care as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

VIII. EFFECTIVE DATE September 1, 2005.

- END -