Chapter 1 Section 10.1

Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC)

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Authority: ASD(HA) Interim Policy Memorandum, March 28, 2002; Section 703, Pub. L. 106-65; Section 107(d), Pub L. 107-107

1.0 DESCRIPTION

1.1 The Individual Case Management Program For Persons With Extraordinary Conditions (ICMP-PEC), also known as the Individual Case Management Program, was a discretionary program for TRICARE beneficiaries with extraordinary medical or psychological conditions. As authorized by the National Defense Authorization Act (NDAA) of 1993, the Individual Case Management Program (ICMP) expanded the former Home Health Demonstration Project which was directed by the 1986 Defense Appropriations Act.

1.2 The purpose of the ICMP-PEC was to provide coverage of medical or psychological services, supplies, or durable medical equipment that are normally excluded by law or regulation as a TRICARE benefit when the provision of such benefits was cost-effective and clinically appropriate. The ICMP-PEC was designed to provide a cost-effective plan of care by targeting appropriate resources to meet the medical needs of a beneficiary with a qualifying condition. In addition, the ICMP-PEC authorized a waiver of the exclusion of custodial care or domiciliary care such that for high cost cases under the parameters of the existing Managed Care Support (MCS) contracts, the ICMP-PEC authorized payment for comprehensive home health care services, supplies and equipment.

1.3 Following publication of the Final Rule in February 1999 (67 FR 7084), the ICMP began March 1, 1999. The ASD(HA) Interim Policy Memorandum of March 28, 2000 changed the name to the ICMP-PEC to focus on beneficiaries with extraordinary or catastrophic conditions.

1.4 Section 701 of the NDAA for Fiscal Year 2002 (NDAA FY 2002) terminated the ICMP/ICMP-PEC effective December 28, 2001. For beneficiaries in the ICMP-PEC as of December 28, 2001, the NDAA Fiscal Year (FY) 2002 also provided that payment will continue as if the ICMP-PEC were still in effect for home health care or custodial care services provided to a beneficiary that would otherwise be excluded from coverage under the new Home Health Agency Prospective Payment System (HHA PPS), the Extended Care Health Option (ECHO), or the Skilled Nursing Facility Prospective Payment System (SNF PPS), until those services are no longer required or can be appropriately provided by other TRICARE programs.

2.0 POLICY

2.1 For TRICARE beneficiaries authorized benefits under the ICMP-PEC as of December 28, 2001, payment will continue to be provided as if the ICMP-PEC were in effect for home health care or custodial care services provided to a beneficiary that would otherwise be excluded from coverage under the new HHA PPS, ECHO, or the SNF PPS.

2.2 For TRICARE For Life (TFL) beneficiaries authorized benefits under the ICMP-PEC as of December 28, 2001, payment will continue to be provided as if the ICMP-PEC were in effect for home health care or custodial care services provided to a beneficiary that would otherwise be excluded from coverage under the new HHA PPS, ECHO, or the SNF PPS. See also the TRICARE Operations Manual (TOM), Chapter 7, Section 1, paragraph 11.0.

2.3 TRICARE payment of services which were authorized by the Home Health Demonstration Project will continue as long as those beneficiaries who were "grandfathered" when that program was terminated, remain eligible for TRICARE.

2.4 ICMP-PEC beneficiaries as of December 28, 2001, whose level of services authorized as of December 28, 2001 can be appropriately provided through other TRICARE programs, such as the HHA PPS, ECHO, or the SNF PPS, shall be transitioned into such program upon identification by the Managed Care Support Contractors (MCSCs) in conjunction with the Director, TRICARE Management Activity (TMA) Office of the Chief Medical Officer, or designee.

2.5 Requirements for continued payment of ICMP-PEC authorized services:

2.5.1 Eligibility. The beneficiary must be TRICARE eligible.

2.5.2 Authorized Beneficiaries. Only those beneficiaries authorized services under the ICMP-PEC upon its termination on December 28, 2001, are eligible for continued coverage.

2.5.3 Authorized Services. Only those services authorized under the ICMP-PEC upon its termination on December 28, 2001, are eligible for continued coverage.

2.5.4 Custodial Care. Beneficiaries must continue to meet the TRICARE definition of custodial care in effect prior to December 28, 2001, that is, custodial care is care rendered to a patient who:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged, and
- Requires a protected, monitored, or controlled environment whether in an institution or in the home, and
- Requires assistance to support the essentials of daily living, and
- Is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

2.5.5 Beneficiaries covered under paragraphs 2.1 or 2.2 must have a primary caregiver in the home.

2.5.6 Reassessment. Continuation of receipt of services requires reassessment on a regular basis. The MCSCs will provide supporting clinical documentation of all authorized participant's medically necessary skilled needs, to include a plan of care signed by the attending physician. Each letter of authorization for continued coverage issued by the Director, TMA Office of the Chief Medical Officer, or designee, will include a statement regarding the frequency of a periodic reassessment of the beneficiary. Generally, periodic reassessment will occur annually, but will be based on the needs of the beneficiary. MCSCs shall provide a complete clinical documentation update and recommendation for continuation of coverage at the same level or indicate if either an increase or decrease in services is indicated by the beneficiary's current needs. TMA will provide a courtesy reminder when a periodic reassessment is due for a beneficiary. Once TMA reviews the reassessment and updated recommendations of the MCSC, a revised or updated authorization letter will be issued to the MCSC.

2.5.7 Revisions. If at any time an MCSC determines a need for a change in authorized funding for a beneficiary (e.g., due to a change in TMAC rates, a change in patient condition, such as a need for more or fewer covered hours, change in HHA, etc.), then the MCSC must submit a written request for such change to the Director, TMA Office of the Chief Medical Officer, or designee, that includes a detailed explanation of why the change is required. The Director, TMA Office of the Chief Medical Officer, or designee, will evaluate each request and provide a written decision to the MCSC.

2.5.8 Cost-shares. Cost-shares shall not be applied to services authorized under the ICMP-PEC prior to December 28, 2001 nor to those services provided under this policy. Cost-shares will continue to apply to all other TRICARE benefits.

2.5.9 Appeals. Appeals should be made directly to the TMA Appeals and Hearings Division. There are three appealable issues related to the ICMP-PEC:

2.5.9.1 A custodial care determination;

2.5.9.2 A determination by the MCSC that ICMP-PEC does not apply;

2.5.9.3 The types and extent of services authorized for a beneficiary by TMA. The following language is to be included in subsequent determination of custodial care letters and notification of benefits related to ICMP-PEC:

> "Should you disagree with this initial determination, you have the right to appeal and request a formal review. Appealable issues include the types and extent of the services and supplies authorized under the ICMP-PEC and the determination that the care is custodial. The request must be in writing, be signed, and must be postmarked or received by the *Appeals and Hearings Division, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066*, within 90 days from the date of this determination. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.

Additional documentation in support of the appeal may be submitted. However, because a request for a formal review must be received within 90 days of the date of the initial determination, a request for formal review should not be delayed pending the acquisition of any additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the formal review must include a statement that additional documentation will be submitted and the expected date of the submission."

2.5.10 Claims Processing. MCSCs are to use the special processing code "CM" in addition to the appropriate branch of service code for all claims for care and services authorized under this policy. MCSCs are to use the special processing code "E" in addition to the special processing code "CM" for claims for services authorized for those beneficiaries indicated in paragraph 2.3. Claims for services not provided in accordance with paragraphs 2.1, 2.2, or 2.3 (i.e., acute outpatient and inpatient care and services, including Durable Medical Equipment (DME)) must be processed in accordance with the TOM, the TRICARE Reimbursement Manual (TRM), and the TRICARE Systems Manual (TSM), and without the use of the special processing codes "E" and "CM".

2.5.11 MCSCs shall notify the Director, TMA Office of the Chief Medical Officer, or designee upon any of the following changes to any beneficiary who is covered by paragraphs 2.1, 2.2, or 2.3.

- death;
- eligibility status, including becoming a Transitional Survivor or a Survivor as those terms are used in Chapter 10, Section 7.1;
- residential relocation (pending or completed);
- custodial care status;
- inpatient admission;
- requests for disengagement.

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