# Extended Care Health Option (ECHO) for Behavioral Health Disorders

## General information about ECHO:

The TRICARE Extended Care Health Option (ECHO) is available to **active duty beneficiaries** who have severe physical or moderate to severe mental disabilities. ALL services or benefits under the Basic TRICARE program are excluded from ECHO. A determination that a beneficiary is not eligible for ECHO is considered a factual determination based on a requirement of the law or regulation and as such is not appealable.

## Eligibility Criteria:

- Available only to active duty family members (ADFMs) who have a qualifying condition
- To be eligible you **must** register for TRICARE ECHO and enroll in your sponsor's service branch's Exceptional Family Member Program (EFMP)
- Qualifying conditions include:
    - Moderate or severe mental retardation
    - A serious physical disability
    - An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound

| SPONSOR PAY GRADE | MONTHLY AMOUNT | SPONSOR PAY GRADE | MONTHLY AMOUNT | SPONSOR PAY GRADE | MONTHLY AMOUNT |
|---|---|---|---|---|---|
| E-1 through E-5 | $25.00 | E-9, O-3, W-1, W-2 | $45.00 | O-7 | $100.00 |
| E-6 | $30.00 | W-3, W-4, O-4 | $50.00 | O-8 | $150.00 |
| E-7, O-1 | $35.00 | O-5, W-5 | $65.00 | O-9 | $200.00 |
| E-8, O-2 | $40.00 | O-6 | $75.00 | O-10 | $250.00 |

- Cost shares have been set by the government. ECHO requires payment of only one monthly cost share by the sponsor.
- ECHO Home Health Care (EHHC) benefit is limited to the amount TRICARE will pay annually if the ECHO-eligible beneficiary resided in a skilled nursing facility (SNF).
- EHHC benefits are only available if rendered in the beneficiary's home. The beneficiary must be homebound and require 2 or more skilled services per 8 hour shift/day.
- In no case will payment be made in advance for services not yet rendered.
- Member may request a monthly pro-ration of the ECHO benefit for expensive durable equipment but not for transportation.
- Public facility available services must be used prior to ECHO.

## Conditions that could qualify for ECHO for Behavioral Health Disorders

- Mental Retardation
- Autistic Spectrum Disorders

**Procedures for obtaining benefits:**

- Submit:
  - ECHO Enrollment form. The beneficiary's Primary Care Manager (PCM) must complete, sign, and date the back side or second page
  - Public Facility Use Verification form (not required for EHHC)
  - Sponsor's Branch of Service's official EFMP Enrollment documentation
- Mail or fax to ValueOptions
- If eligibility is confirmed, the sponsor will receive written notification of the ECHO registration and authorizations for ECHO services
- Periodic review and reevaluation will be conducted by a dedicated case manager.

**Examples of covered services and supplies:**

- As a general rule, the services and supplies covered under ECHO are those that contribute to the habilitation and rehabilitation of the handicapped dependent and are not a benefit under Basic TRICARE.
- Institutional care (primarily for long term residential care in private nonprofit, public or state institutions or facilities…schools for deaf and blind)
- Durable equipment
- Home Health Care (skilled care and homebound status are required)
- Professional services (must be licensed within the jurisdiction in which services are provided).
- Special tutoring (private tutoring to supplement a public education or special education enhancement program is covered).
- Training and special education (cannot exceed high school level)
- Transportation (covers to and from public or private nonprofit facilities. Carpooling required whenever necessary. Public transportation ticket price is reimbursable).

**Examples of non-covered services:**

Specialized academic education (usually provided in a public school system or institution of higher learning)

- Alteration (refers to living space and permanent fixtures to accommodate medical equipment)
- Homemaker, sitter or companion services
- Dental care
- FDA non-approved drugs and medications
- Any care or facility outside the United States
- Meals, motels or tips
- Any service currently provided as a benefit under Basic TRICARE program.
- Therapeutic absences from an inpatient facility
- Domiciliary care
- Custodial care
- Additional or special charges for excursions
- Services for a beneficiary aged 3 to 21 that are written in the beneficiary's special education Individual Educational Plan (IEP).

**REQUEST FOR TRICARE BENEFITS**
**UNDER EXTENDED CARE HEALTH OPTION (ECHO) for Behavioral Health Diagnosis and ECHO Health Care (EHHC)**

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information.

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|---|---|
| AUTHORITY: | 32 CFR 199.5 |
| PRINCIPAL PURPOSE: | To determine eligibility for the ECHO Program |
| ROUTINE USES(s): | To locate and correspond with sponsor, determine appropriateness and cost of care, and issue written approvals and authorize payment of claims. |
| DISCLOSURE: | Voluntary; however, failure to provide complete information may result in the denial of benefits. |

## PART 1 – INSTRUCTIONS TO SPONSOR

1. All information on both sides of this form must be completed prior to approval for payment of benefits.
2. ECHO benefits are limited to TRICARE-eligible active duty family members with moderate or severe mental retardation or a serious physical disability. Exceptional Family Member Program enrollment is mandatory. Beneficiary must be homebound and require more than two skilled services per 8 hour shift in order to receive EHHC benefits. EHHC requires a physician-certified plan of care.
3. Under ECHO, the sponsor pays an initial share of the monthly cost according to sponsor's pay grad (see table below); the amount paid by the government will not exceed $36,000/year unless the beneficiary is enrolled in EHHC. EHHC is subject to a fiscal year cap.

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## PART 2 – SPONSOR INFORMATION

| 1. SPONSOR NAME (Last, First, MI) | 2. RANK AND PAY GRADE | 3. BRANCH OF SERVICE | 4. SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| 5. COMPLETE MILITARY ADDRESS (Street, City, State, and Zip Code)<br><br>TELEPHONE AREA ( )<br>EXT. | 6. HOME ADDRESS (Street, City, State, and Zip Code)<br><br>TELEPHONE AREA CODE ( ) |
|---|---|

## PART III – PATIENT INFORMATION

| 7. PATIENT NAME (Last, First, MI) | 8. DATE OF BIRTH (YY/MM/DD) | 9. RELATIONSHIP TO SPONSOR (i.e., Son, Daughter, Spouse) |
|---|---|---|
| | | |

| 10. HOME ADDRESS (Street, City, State and Zip Code)<br><br>TELEPHONE AREA CODE ( ) |
|---|

| 11. SIGNATURE OF SPONSOR, PATIENT, OR LEGALLY RESPONSIBLE PERSON | 12. RELATIONSHIP TO PATIENT (i.e., Mother, Father) | 13. DATE SIGNED |
|---|---|---|
| | | |

| PART IV – PROVIDER INFORMATION | |
|---|---|
| 14. BRIEF MEDICAL HISTORY, DIAGNOSIS (Use ICD Code), PRESENT CONDITION, AND LIMITATIONS | |
| 15. RECOMMENDATION / ORDERS | |
| 16. TYPE OR PRINT PHYSICIAN'S NAME | 17. PHONE NUMBER |
| 18. SIGNATURE OF PHYSICIAN (For all above information) | 19. DATE SIGNED (YY/MM/DD) |

MAIL COMPLETED FORM TO:
ValueOptions – TRICARE South
C/O ECHO/EHHC Program
P.O. Box 551188
Jacksonville, FL 32255
Or fax to:
(866) 811-4422

| PUBLIC FACILITY USE CERTIFICATION | | |
|---|---|---|
| BENEFICIARY NAME (Last, First, MI) | SPONSOR'S SOCIAL SECURITY NUMBER | |
| SERVICE(S) BEING REQUESTED | | |
| DESCRIBE THE EXTENT, TYPE, FREQUENCY, AND FUNDING OF REQUESTED AVAILABLE SERVICE (ABA Therapy, Respite, etc.) | | |
| NAME AND TITLE OF PUBLIC OFFICIAL (Typed or Printed) | PUBLIC AGENCY'S NAME | |
| SIGNATURE OF PUBLIC OFFICIAL | PHONE NUMBER<br>( ) | DATE |

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