

## Chapter 11

## Section 5

# Hospice Reimbursement - Concurrent Hospice Services And Curative Care For Pediatric Beneficiaries

Issue Date: August 6, 2019

Authority: 10 USC Section 1079(A)(15)

Revision: C-39, August 6, 2019

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### 1.0 APPLICABILITY

This policy is mandatory for the coverage and reimbursement of concurrent hospice services and curative care for the same condition (hereinafter referred to as "concurrent care") for TRICARE eligible beneficiaries under the age of 21.

### 2.0 ISSUE

The conditions which shall be met and the procedural guidelines for reimbursement of concurrent care.

### 3.0 POLICY

#### 3.1 Statutory Background

Section 704 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018 authorizes the Defense Health Agency (DHA) to provide concurrent curative Basic Program benefits to beneficiaries under the age of 21 for the same condition for which they are enrolled in the TRICARE hospice benefit. This allows continued coverage of medically necessary curative treatment, even after election of the hospice benefit by or on behalf of beneficiaries under the age of 21. Medical necessity and appropriateness of care shall remain the criteria for coverage of curative services while elected hospice services shall provide the palliative services and support to help children and their families live as normally as possible, addressing physical, emotional, social, and spiritual aspects of suffering. Overall, an organized system of holistic care will improve the quality of life for children with terminal illnesses.

#### 3.2 Scope Of Coverage

**3.2.1** Beneficiaries under the age of 21 who have a diagnosis of a terminal illness with a life expectancy of six months or less if the terminal illness runs its normal course are eligible for medically necessary curative treatment (i.e., treatment covered under the TRICARE Basic Program) related to the illness in addition to palliative care provided under the hospice benefit. Once a beneficiary turns age 21, they are no longer eligible for concurrent care.

**3.2.2** Coverage of curative treatment related to the terminal illness extends to treatment provided by individual health care professionals and other non-institutional/non-professional providers, as well as institutional providers (both inpatient and outpatient settings). Authorized providers include only the categories of providers detailed in [Section 2](#) and providers who are authorized providers of care under the TRICARE Basic Program.

**3.2.3** All conditions for coverage detailed in [Section 2](#) also apply.

### **3.3 Preauthorization Requirement**

Preauthorization is required for the coverage and reimbursement of concurrent care provided to beneficiaries under the age of 21 in order to ensure collaboration between the hospice and referring outside providers. The preauthorization of concurrent care is especially relevant given the enhanced case management responsibilities of the contractor for ensuring collaboration between the hospice and other providers and suppliers rendering curative services. The preauthorization process shall also verify the following beneficiary eligibility criteria for concurrent care:

#### **3.3.1 Beneficiary Eligibility Criteria**

**3.3.1.1** The beneficiary is under the age of 21 and has a diagnosis of a terminal illness with a life expectancy of six months or less if the terminal illness runs its normal course.

**3.3.1.2** The referring healthcare provider has identified the eligible beneficiary for referral to the participating hospice.

**3.3.1.3** A signed and dated certification/attestation of the terminal illness has been obtained from the referring provider and hospice medical director.

**3.3.1.4** The beneficiary has met the hospice eligibility and admission criteria.

**3.3.1.5** The contractor shall issue an authorization or denial letter to the referring healthcare provider, hospice, and beneficiary once a determination has been made as a result of the preauthorization review process.

**3.3.1.6** The contractor shall manage and resolve all inquiries related to the preauthorization review process and the resulting final determination.

### **3.4 Conditions For Coverage**

The pre-election process, election process, and other conditions for coverage shall follow the same requirements and procedures listed in [Section 3](#), with the following exceptions:

**3.4.1** TRICARE Basic Program services (i.e., those services which are normally considered curative in nature) related to the treatment of the terminal illness for which hospice care was elected and provided during the hospice election shall be billed to the contractor for non-hospice reimbursement. This reimbursement is in addition to the non-hospice reimbursement currently available for direct patient care services rendered by either an independent attending physician or physician employed by or under contract with a hospice and for treatment of non-related conditions.

**3.4.2** Coverage of Basic Program services for beneficiaries under the age of 21 shall no longer require election revocation. Reimbursement of these Basic Program services shall not be subject to the hospice payment limits as prescribed in [Section 4, paragraph 3.1.6](#) and [3.1.7](#).

**3.4.3** If the curative care is successful and a physician determines the beneficiary no longer has a life expectancy of six months or less if the terminal illness runs its normal course, and the beneficiary revokes the hospice election, but the beneficiary's disease later returns or the beneficiary is diagnosed with a new condition that reduces the beneficiary's life expectancy to six months or less, then the beneficiary is exempt from the limitation on episodes of care detailed in [Section 3](#), and is eligible for two additional 90-day episodes of care, followed by an unlimited number of 60-day periods.

### **3.5 Treatment Plan**

**3.5.1** A consolidated treatment plan shall be required for beneficiaries under the age of 21 who are also receiving concurrent care, requiring coordination and case management services both within the hospice and between the hospice and other providers and suppliers rendering curative services with the goal of achieving better patient-centered outcomes and supporting shared decision-making. The treatment plan for beneficiaries receiving concurrent hospice services and curative care shall include the requirements in [Section 3, paragraph 3.4](#).

**3.5.2** The hospice is expected to conduct ongoing communication and education with the patient and their family regarding coordination of treatment plans and treatment options as prescribed by those providers and suppliers rendering curative services.

**3.5.3** The hospice care coordinator shall be responsible for performing care coordination and case management with the referring providers outside the hospice. The contractor shall require the beneficiary's care to be tracked using a monthly service and activity log which includes, at a minimum, the following:

- Primary diagnosis and co-morbidities;
- Services provided, both palliative and curative;
- Staff categories providing the services; and
- Number and length of visits pertaining to both palliative and curative services.

### **3.6 Medical Review Process**

**3.6.1** Concurrent care for beneficiaries under the age of 21 shall require enhanced case management and medical review by the contractor to ensure collaboration between the hospice and other providers and suppliers rendering the curative treatment (i.e., Basic Program services provided in addition to the palliative services rendered during the hospice election). This shall involve monitoring and evaluation of the following key functional elements used in carrying out care coordination and shared decision-making between the hospice and other providers and suppliers:

- Letters of engagement from those providers/suppliers with whom the hospice has an established relationship (either a formal legal relationship, or an established informal relationship).
- Designated staff members responsible for interactions and communication between the hospice and outside providers/suppliers;

- Policies, procedures, or other mechanisms used to coordinate services and to collaborate with physicians and other healthcare providers;
- Mechanisms in place to resolve conflicts in care coordination and case management between providers (e.g., in situations when there are inconsistencies or overlapping of hospice and Basic Program services);
- Mechanisms in place which ensure that clinically appropriate services are available, regardless of the location where the hospice care is provided during the hospice election period; and
- Internal controls to ensure that duplicate claims are rejected.

**3.6.2** The contractor shall have overall responsibility of case management under concurrent care requiring medical review and evaluation of a consolidated treatment plan along with a monthly service and activity log to ensure consistency and appropriateness of hospice and Basic Program services. Medical necessity and appropriateness of care shall remain the criteria for coverage of Basic Program services while elected hospice services shall provide the palliative services/support to help children and their families live as normally as possible, addressing physical, emotional, social, and spiritual aspects of suffering. The contractor shall identify and deny claims for any duplicative services during the post-payment medical review process (i.e., where there is a duplication or overlapping of services between the hospice and curative providers).

**3.6.3** Contractor case management shall also facilitate identification of duplicative services (i.e., where the same services are provided by both the hospice and referring healthcare provider or other TRICARE-authorized providers) through the review of consolidated Plans of Care (POCs), monthly service and activity logs, and claims data. Contractors shall ensure that duplicate claims are rejected.

**3.6.4** The contractor's case management process shall also facilitate how the treatment of relative services are categorized and billed under the TRICARE program (i.e., whether they are considered curative or palliative in nature). The process for this evaluation shall reflect an understanding that each beneficiary's circumstance is unique and that decisions about what is curative reflects each beneficiary's individual needs. As a result, determinations of what constitutes curative services for a beneficiary shall be made on a case-by-case basis.

**Example:** If a blood transfusion was performed as a curative treatment for the condition, then the Basic Program would be responsible for the expense. If, on the other hand, it was for pain and symptom control, then the hospice provider would absorb the expense. A review of either the physician's orders or the consolidated POC may assist the hospice provider and contractor in determining the purpose of the service or treatment. The contractor would reimburse the authorizing provider for the curative services, but would continue to reimburse hospice providers for hospice services.

**3.6.5** The contractor shall be responsible for the establishment of procedural protocols with the hospice and providers/suppliers rendering concurrent care for submission and review of consolidated treatment plans and monthly service and activity logs in order to assess and manage the beneficiary's ongoing care.

**3.6.6** The contractor shall conduct random audits of the beneficiary's medical records to compare the consolidated POC to the monthly service and activity log to ensure that the services provided reasonably match the POC.

### **3.7 Referring Provider And Hospice Requirements**

**3.7.1** The referring healthcare provider shall identify the eligible beneficiary for referral to the participating hospice and attest that the beneficiary meets the eligibility criteria.

**3.7.2** Once a beneficiary's eligibility is established, the hospice shall conduct a comprehensive assessment that follows the hospice conditions of participation (CoPs).

**3.7.3** A consolidated POC requiring coordination and case management, both within the hospice and between the hospice and other providers and suppliers rendering the curative treatment, shall be completed within three days of referral by the referring provider. The consolidated POC shall be reviewed, revised, and documented at least every 15 calendar days as required by the hospice CoPs. The consolidated POC shall provide a detailed breakdown of hospice and curative services.

**3.7.4** The hospice shall have formal policies and procedures in place for care coordination, case management, and shared decision-making with referring physicians and other healthcare providers having admitting and/or ordering privileges.

**3.7.5** The participating hospice shall have designated staff members responsible for interaction and communication between the hospice and outside providers and suppliers.

**3.7.6** The hospice shall perform ongoing communication and education with the beneficiaries and their families regarding coordination of treatment plans and treatment options as prescribed by those providers and suppliers rendering the curative treatment.

**3.7.7** The hospice care coordinator shall have overall responsibility for ensuring and monitoring care coordination and case management with outside providers/suppliers. The hospice care coordinator, along with appropriate interdisciplinary team members, shall meet on a weekly basis (either telephonically or in person) with their curative provider counterparts to review and revise, if necessary, the beneficiary's consolidated POC. The beneficiary's care shall be tracked using a monthly service and activity log as discussed in [paragraph 3.5.3](#).

**3.7.8** The hospice shall submit consolidated treatment plans and service/activity logs to the contractor on a monthly basis, along with any additionally requested medical documentation. This shall ensure that the actual services performed reasonably match the consolidated POC.

## **4.0 REIMBURSEMENT**

Reimbursement for services under this section shall follow the same methodology, requirements, and procedures detailed in [Section 4](#), with the following exceptions:

**4.1** Continued coverage and reimbursement of medically necessary curative treatment is available to beneficiaries under the age of 21 who have elected coverage under the TRICARE Hospice Benefit (THB). This reimbursement shall be extended for medically necessary curative treatment provided by

individual health care professionals and other non-institutional/non-professional providers, as well as institutional providers (both inpatient and outpatient settings).

**4.2** Payment for the curative treatment shall be subject to the standard Basic Program reimbursement methodologies in place for the specific provider category and setting rendering the care (e.g., CHAMPUS Maximum Allowable Charges (CMACs) for professional services and Diagnostic Related Groups (DRGs) for institutional care).

**4.3** All payments for curative treatment shall be subject to established cost-sharing and deductible provisions.

**4.4** Reimbursement of these Basic Program services shall not be subject to the hospice payment and inpatient limits as prescribed in [Section 4, paragraph 3.1.6](#) and [3.1.7](#).

**4.5** The hospice shall notify the contractor of all outside providers rendering curative treatment as part of the consolidated treatment plan and monthly service and activity log. This shall allow for the appropriate reimbursement of curative treatment for beneficiaries under the age of 21 electing hospice care. The contractors' enhanced case management and review process shall ensure the proper integration of curative and palliative services, thus improving the quality of life for children with complex life-threatening conditions. It shall also prevent the reimbursement of duplicative services.

## **5.0 EFFECTIVE DATE**

December 12, 2017, for reimbursement of concurrent care for TRICARE eligible beneficiaries under the age of 21.

## **6.0 EXCLUSION**

TRICARE Overseas Program (TOP) beneficiaries are not subject to the requirements of this policy.

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