CHAPTER 11
SECTION 3

HOSPICE REIMBURSEMENT - CONDITIONS FOR COVERAGE

ISSUE DATE: February 6, 1995
AUTHORITY: 32 CFR 199.4(e)(19)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

The conditions which must be met in order to receive reimbursement for hospice care.

III. POLICY

The following conditions/criteria must be met in order to receive reimbursement for hospice benefits and services referenced in Chapter 11, Section 2:

A. Election Process.

1. Election Periods. The beneficiary must elect to receive hospice care for each specified period of time unless the care is continuous throughout subsequent election periods; i.e., where there is not a break in care. If the beneficiary is found to be mentally incompetent, his or her representative may file the election statement.

a. Patients with a life expectancy of six months or less if the illness runs its normal course may receive the following episodes of care.

(1) Hospice benefit periods available to beneficiaries prior to August 5, 1997:

(a) Two 90-day periods;

(b) One 30-day period; and

(c) A final period of unlimited duration.

(2) Hospice benefit periods available to beneficiaries on or after August 5, 1997;

(a) Two initial 90-day; and

(b) An unlimited number of subsequent 60-day periods.

(3) Transition guidelines for phasing in new benefit periods for those beneficiaries making an election prior to August 5, 1997:

(a) Beneficiaries in their third period (i.e., the 30-day election period available to beneficiaries prior to August 5, 1997), will be automatically considered in their first subsequent period of 60 days. The period will be considered to have begun on August 5, 1997. Recertification will be required at the beginning of the next 60-day period and every 60-day period thereafter.

(b) Beneficiaries in their fourth period will be considered as having begun their first 60-day period as of August 5, 1997, and the first recertification will be required at the beginning of the next 60-day period, and for every 60-day period thereafter.

(c) The benefit period changes (i.e., those changes in effect on or after August 5, 1997), apply to the hospice benefit regardless of whether or not an individual had made an election of the benefit prior to August 5, 1997.

1 A beneficiary who elected hospice prior to August 5, 1997, and was discharged from hospice care at some future time because he or she is no longer terminally ill could avail themselves of the benefit at some later date if they should become terminally ill again and otherwise meet the requirements of the hospice benefit.

2 If the beneficiary had been discharged during the initial 90-day period, he or she would enter the benefit in the second 90-day period

3 If the discharge took place during the final 90-day or any subsequent 60-day period, the beneficiary would enter the benefit in a new 60-day period.

4 A beneficiary who had been discharged from hospice during the fourth benefit period prior to August 5, 1997, would be eligible for the benefit again and would begin it in a 60-day period. The 90-day periods would not be available since only two 90-day periods are allowed during the beneficiary's lifetime.

5 There is no limit on 60-day periods as long as the beneficiary meets the requirements for the hospice benefit.

b. These episodes of care must be used consecutively; that is, the two 90-day periods must be used before the unlimited 60-day periods. The periods of care may be elected separately at different times.

NOTE: There may be gaps in between the episodes of care. If there is any break in hospice care, a distinct/separate election must be made for a subsequent episode of

hospice care. There are no time requirements between election periods; i.e., an individual may at any time elect to receive hospice coverage for any other hospice election period for which he or she is eligible. The beneficiary will revert back to Basic TRICARE during these gaps in time between election periods.

c. The initial election will continue through subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election.

NOTE: The contractor must query DEERS in order to process, store and reply to a specific election notification. The initial DEERS eligibility will be applicable for benefits, including the continuation of an initial election through subsequent election periods where there is no break in care. However, another DEERS query and reply must be initiated once a distinct/separate election has been made for a subsequent episode of hospice care.

d. The effective date of the election may begin on the first day of hospice care or any subsequent day of care, but the effective date cannot be made prior to the date that the election was made.

e. The beneficiary or representative may revoke a hospice election, but in doing so, he or she forfeits the remaining days in the election period and resumes coverage of the benefits waived under that election.

(1) To revoke the election of hospice care, the individual must file a document with the hospice that includes:

(a) A signed statement that the individual revokes the election for coverage of hospice care for the remainder of the election period; and

(b) The date that the revocation is to be effective.

(2) After revoking a particular election period, the beneficiary may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(3) If a beneficiary revokes the final period of unlimited duration, he or she is no longer entitled to hospice care.

EXAMPLE: A patient elects to receive care under the second 90-day period after completing the first 90-day election period, and then after 60 days of that care, decides to revoke the election. The remaining days (30 days) of the election period would be forfeited. However, the patient could at any time elect to receive coverage for any other hospice election period for which he or she was eligible. In this particular case, it would be the next 30-day period.

f. A beneficiary or representative may also change from one hospice program to another once in each election period. The change is accomplished by submitting a signed

statement addressed both to the hospice from which the patient received care and to the newly designated hospice. The change of the designated hospice is not a revocation of the election for the period in which it is made.

(1) The statement shall include the following information:

(a) The name of the hospice from which the individual has received care;

(b) The name of the hospice from which the patient plans to receive the care; and

(c) The date the change is to be effective.

(2) A change of ownership of a hospice program is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part.

g. The beneficiary must waive all rights to other TRICARE payments for the duration of the election period for:

(1) Care provided by any hospice program other than the elected hospice unless provided under arrangement made by the elected hospice; and

(2) Other TRICARE basic program services/benefits related to the terminal illness for which hospice care was elected, or to a related condition, or that are equivalent to hospice care, except for services:

(a) Provided by the designated hospice;

(b) Provided by another hospice under arrangements made by the designated hospice; and

(c) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

h. Basic program coverage will be reinstated upon revocation of the hospice election.

i. Covered services not related to the treatment of the terminal condition for which hospice care was elected and provided during a hospice election period may be billed to the contractor for nonhospice reimbursement.

(1) These services are billed by the provider in accordance with existing procedures as a new admission subject to standard reimbursement methodologies.

(2) The contractor will identify and review all nonhospice inpatient claims for beneficiaries who have elected hospice care to make sure that:

(a) For nonrelated hospital admissions, nonhospice coverage is provided to a beneficiary only when hospitalization was for a condition not related to his or her terminal illness; and

(b) For conditions related to a beneficiary's terminal illness, the claims were denied.

NOTE: Many illnesses may occur when an individual is terminally ill which are brought on by the underlying condition of the patient. For example, it is not unusual for a terminally ill patient to develop pneumonia or some other illness as a result of his or her weakened condition. Similarly, the setting of bones after fractures occur in a bone cancer patient would be treatment of a related condition.

j. The beneficiary may receive inpatient hospice care (both general and respite) in a military treatment facility (MTF) without revocation of an election as long as the following conditions are met:

(1) The attending MTF physician is involved in the overall treatment planning of the hospice patient; i.e., a part of the interdisciplinary group responsible for determining the scope and frequency of services needed to meet the patient's and family's needs.

(2) The hospice program for which the election is granted maintains ultimate professional management of the patient while in the MTF; i.e., services provided in the MTF setting are coordinated with the hospice medical staff.

(3) The MTF inpatient care is strictly palliative in nature and in keeping with the overall hospice treatment plan.

2. Election Statements.

a. A beneficiary who elects to receive hospice care must file an election statement with a particular hospice. Each hospice must design and print its own election statement to include the following information:

(1) Identification of the particular hospice that will provide care to the individual;

(2) Individual's or representative's acknowledgment that he or she has been given a full understanding of hospice care;

(3) Individual's or representative's acknowledgment that he or she understands that certain other services are waived by the election;

(4) Effective date of election; and

(5) Signature of the individual or representative.

b. An election statement may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

NOTE: "Representative" means an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is found to be mentally incompetent.

c. The hospice representative must make sure that the required election statement is in the clinical records before signing the Notice of Admission (the UB-92 is used for this purpose). The representative must also enter the admission date, which must be the same date as the effective date of the hospice election.

3. Contractor Notification. The hospice must notify the contractor of the initiation, change or revocation of any election.

a. Election initiation. The Form UB-92, Uniformed Institutional Billing Form, will be used as an admission and election notice.

(1) When a beneficiary is admitted for hospice services, items 1, 4, 5, 12, 13, 14, 15, 17, 58, 60, 67, 82, 83, and 86 must be completed by the hospice for which the beneficiary has elected to receive care.

NOTE: Items 1, 4, 5, 12, 13, 14, 15, 17, 58, 60, 67, 82, 83, and 86 are the only items that should be completed on the Notice of Admission (UB-92). Billing for actual services should be done on a separate UB-92.

(2) The completed form must be sent to the contractor having jurisdictional authority for that particular hospice program.

NOTE: Since the managed care support contractor is responsible for providing all health care to beneficiaries residing within its contract area, election information should be submitted to the managed care support contractor regardless of where the care is provided; e.g., if the beneficiary from a managed care support area receives hospice care outside the contract area, the election notification should be sent to the managed care support contractor rather than the contractor having regional jurisdiction.

(3) The admission and election notice (UB-92) should be submitted to the contractor as soon as possible after admission of a beneficiary. If any of the items are absent, normal development procedures should be followed (refer to paragraph III.A.4.e. below for specific information requirements).

(4) The information may be forwarded by mail or telephone depending upon the facility's arrangement with the contractor.

(5) The following are detailed instructions for completing the admission notice (UB-92):

Item 1. Provider Name, Address, and Telephone Number Required.

Enter name, city, state, and ZIP code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations.

Item 4. Type of Bill Required. Enter the three-digit type of bill code: 81A or 82A as appropriate.

Code Structure

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

1 - Hospice (Nonhospital Based)

2 - Hospice (Hospital Based)

3rd Digit - Frequency

A - Admission Notice

Definition: Notify the contractor responsible for processing your claims of the beneficiary's election of hospice benefits by forwarding Form UB-92.

Item 5. Federal Tax Number. Enter tax identification number (TIN) or employer identification number (EIN) and the sub-ID assigned by the contractor.

Item 12. Patient's Name Required. Show the patient's name with the surname first, first name, and middle initial, if any.

Item 13. Patient's Address Required. Show the patient's full mailing address including street name and number or RFD, city, state, and ZIP code.

Item 14. Patient's Birthdate Required. Show the month, day, and year of birth numerically as MM-DD-YY. If the date of birth cannot be obtained after a reasonable effort, leave this field blank.

Item 15. Patient's Sex Required. Show and "M" for male or an "F" for female.

Item 17. Admission Date Required. Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

EXAMPLE: The hospice election (admission) is January 1, 1994. The physician's certification is dated January 10, 1994. The hospice admission date for coverage and billing is January

8, 1994. The first benefit period will end 90 days from January 8, 1994.

Item 38. Transferring Hospice I.D. Required. Only when the admission is for a patient who has changed an election from one hospice to another.

Item 58A, B, C. Insured's Name Required. If the primary payer(s) is other than TRICARE, enter the name of person(s) carrying other insurance in 58A or 58A and 58B as recorded on ID card. If TRICARE is primary, enter the sponsor's name as recorded on the ID card, in line 58A.

Item 60A, B, C. Certificate/Social Security Number/Health Insurance Claim/Identification Number. If primary payer(s) is other than TRICARE, enter the unique ID number assigned by the primary payer to the person(s) carrying other insurance in line 60A or 60A and 60B. Enter the sponsor's social security number in line 60B or 60C if TRICARE patient; or enter the NATO in line 60B or 60C if a NATO beneficiary.

Item 67. Principle Diagnosis Code Required. Show the full ICD-9-CM diagnosis code. The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the patient's admission.

Item 82. Attending Physician I.D. Required. Enter the name, number and address of the licensed physician normally expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment. Use item 94 "Remarks" for additional space for recording this information.

Item 83. Other Physician I.D. Required. Enter the word "employee" or "nonemployee" here to describe the relationship that the patient's attending physician has with the hospice program.

Item 86. Provider Representative Signature and Date Required. A hospice representative makes sure that the required physician's certification and a signed hospice election statement are in the records before signing the UB-92.

b. Contractor's Reply to Notice of Admission. The reply to the notice of admission is furnished according to the contractor's arrangements with the particular hospice program. Whether the reply is given by telephone, mail or wire, it is based upon the contractor's query of DEERS. The purpose of the reply is to inform the hospice that the admission has been received and that the beneficiary is eligible for coverage under TRICARE.

c. Change of Election. The second (receiving) hospice will use Item 38 of the admission notice to indicate a change of election from one hospice program to another.

(1) When a receiving hospice submits an admission notice involving a patient who changed from one hospice to another, this item reflects the transferring hospice's complete name, address, and provider number (refer to Item 38 above).

(2) This information is to alert the contractor that the hospice admission continues a hospice benefit period rather than beginning a new one.

d. Revocation of Election. The contractor will be notified of the beneficiary's revocation of his or her hospice election through item 32 of the UB-92.

CODE	TITLE	DEFINITION
42	Termination of Hospice Care	The date the patient's hospice care ends. Care may be terminated by a change in the hospice election to another hospice, a revocation of the hospice elcetion, or death. Show termination code 42 in item 32.

4. Monitoring of elections.

a. The contractor will have to develop and maintain a screen for the tracking of elections made by beneficiaries. The screen will include:

(1) The specific election period (two 90-day periods, one 30-day period and a final period of unlimited duration);

(2) The inclusive dates for which hospice care will be covered; and

(3) Revocations and transfers between hospice programs.

b. The above information will be reported to the contractors by use of the UB-92 (for both Admission Notice and billing).

c. Once the beneficiary elects hospice care he/she waives all rights to standard TRICARE coverage except for services unrelated to the terminal illness.

d. An election must be onfile in order for coverage to be extended under the hospice benefit.

NOTE: It is assumed that this tracking mechanism will be similar to that of the low volume mental health providers where an authorization must be on file in order for payment to be extended.

e. After the contractor has determined that an election (inclusive dates) is on file for the dates of service submitted on the claim, it will be priced according to the provisions established in Chapter 11, Section 4.

B. Certification Process. There must be written certification in the medical record that the TRICARE beneficiary is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

1. Timing of certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph III.A., even if a single election continues in effect for two, three of four periods.

a. Timing Requirements Prior to August 5, 1997.

(1) Except as provided in paragraph III.B.2.a.(2) below, the hospice must obtain the written certification no later than two calendar days after the period begins.

(2) For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

b. Timing Requirements On or After August 5, 1997.

(1) Physician certification continues to be required no later than 2 days after hospice care begins, but written certification need only be on file in the patient's record prior to submission of a claim to the contractor.

(2) The above requirement applies to beneficiaries who have been previously discharged during a fourth benefit period and were being certified for hospice care again to begin a 60-day benefit period.

2. Sources of certification. Physician certification is required for both initial and subsequent election periods.

a. For the initial 90-day period, the hospice must obtain certification as prescribed in paragraph III.B., above, from:

(1) The individual's attending physician if the individual has an attending physician; and

(2) The medical director of the hospice or the physician member of the hospice interdisciplinary group.

b. For subsequent periods, the only requirement is certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group.

3. Failure to meet the above time frames will result in denial of coverage/payment for those days of care preceding the date of signature on the certification statements.

EXAMPLE: The hospice election is January 1, 1998. The physician's certification is dated January 10, 1998. The hospice admission date for coverage and billing is January 8, 1994. The first hospice benefit period will end 90 days from January 8, 1998.

4. The hospice representative must make sure that the physician's certification is obtained prior to signing the Notice of Admission (the UB-92 is used for this purpose). The representative must also enter the admission date which must be the same date as the effective date of the hospice election.

5. Although the contractor does not require the actual certification statement for processing of hospice claims as a part of the permanent clinical records, it will be reviewed during post-payment medical review.

C. Treatment Plan.

1. In establishing the initial plan of care the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care.

2. At least one of the persons involved in developing the initial plan must be a nurse or physician.

3. The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

4. The other two members of the basic interdisciplinary group -- the attending physician and the medical director or physician designee -- must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessment.

NOTE: A meeting of group members is not required within this 2-day period; input may be provided by telephone. Medical directions and physician members of the interdisciplinary group are no longer required to be employed by the hospice. These physicians can now be under contract with the hospice. However, hospices retain professional management responsibilities for these services and must ensure that they are furnished in a safe and effective manner by qualified persons.

5. Hospice services must be consistent with the plan of care for coverage to be extended.

6. The plan must be reviewed and updated, at intervals specified in the plan, by the attending physician, medical director or physician designee and interdisciplinary group. These reviews must be documented in the medical records.

7. The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each patient.

8. The plan must include an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

D. Medical Review Process.

1. The contractor is required to request and review medical records (post-payment medical review), including the written plan of care, to assure the services were:

a. Covered hospice services;

b. Stipulated in the plan(s) of care;

c. Necessary for the palliation or management of the beneficiary's terminal illness; and

d. Appropriately classified for payment purposes.

NOTE: The accuracy of the billing and appropriateness of care will be looked at as part of the contractor medical review process. The contractor will only be responsible for looking for trends/patterns on a random sampling of claims.

2. Hospice programs will be required to submit all medical records and documentation to the claims processing contractor within 30 days of the date of their request. Failure to submit the contractor requested information will result in recoupment of the claim payment.

3. Although a plan of care will not be needed for the processing of claims, it will be reviewed retrospectively as part of the medical records. The contractor will review the initial plan and all changes through the post-payment medical review process.

E. Provider Certification.

1. Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR 418) relative to TRICARE patients in order to receive payment under the TRICARE program. The hospice program can be either a public agency or private organization (or a subdivision thereof) which:

a. Is primarily engaged in providing the care and services described in Chapter 11, Section 2 and makes such services available on a 24-hour basis.

b. Provides bereavement counseling for the immediate family or terminally ill individuals.

c. Provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the hospice program, except that the agency or organization must:

(1) Routinely supply a substantial amount of the nursing and physician services; medical supplies and appliances; and counseling services for the patient and his or her family.

(2) Maintain professional management responsibility for all services which are not directly furnished to the patient, regardless of the location or facility in which the services are rendered.

(3) Provide assurances that the aggregate number of days of inpatient care (both general inpatient and respite care) provided in any 12-month period does not exceed 20 percent of the aggregate number of hospice days of care during the same period.

(4) Have an interdisciplinary group composed of the following personnel who provide the care and services described in Chapter 11, Section 2 and establish the policies governing the provision of such care/services:

(a) A physician;

(b) A registered nurse;

(c) A social worker; and

(d) A pastoral or other counselor.

(5) Maintain central clinical records on all patients.

(6) Utilize volunteers.

(7) In case of an agency or organization in any state in which state or applicable local law provides for the licensing of agencies or organizations of this nature, is licensed pursuant to such law.

2. The hospice program must also enter into an agreement with TRICARE in order to be qualified to participate, and to be eligible for payment under the program. In this agreement the hospice and TRICARE agree that the hospice and its employees will:

a. Not charge the beneficiary, beneficiary's sponsor, family or representative for items or services for which the beneficiary is entitled to have payment made under the hospice benefit.

b. Be allowed to charge the beneficiary for items or service requested by the beneficiary in addition to those that are covered under the hospice benefit.

NOTE: TRICARE beneficiaries may be charged for requested services not covered by TRICARE when the beneficiary or family representative has been informed that the service/supply is not a TRICARE hospice benefit.

c. Be licensed in accordance with applicable Federal, State and local laws and regulations.

d. Meet such other requirements as the Secretary of Defense may find necessary in the interest of the health and safety of the individuals who are provided care and services by such agency or organization.

3. The TRICARE hospice participation agreement is not time-limited and has no fixed expiration date. The agreement remains in effect until such time as there is a voluntary or involuntary termination.

4. The contractors have participation agreement signatory authority for certification of hospice programs within their geographical jurisdiction subject to the following requirements:

a. The senior contractor official for TRICARE business is to notify the TMA Operations Directorate in writing of the appointment and removal of each person designated by the contractor to sign a hospice participation agreement.

b. The appointment or removal notification must include the individual's full name as signed, title/position, signature sample (for notice of appointment only) and the effective date of the action.

c. No more than two individuals will be so authorized by the contractor concurrently, and the effective date of appointment will be no earlier than the date of the written notice of appointment to the Operations Directorate.

NOTE: These reporting requirements are designed to provide some type of accountability at the contractor level (the contractors responsible for claims processing) for review and signature of hospice participation agreements. There are no specific criteria for selection of these individuals. The notifications will be maintained on file by the Operations Directorate.

5. Application.

a. A complete application for certification as a TRICARE participating hospice program consists of an application signed and dated by the requesting provider which includes:

(1) The complete name and address of the applicant.

(2) The employer identification number (EIN).

(3) Routine and emergency phone numbers for the applicant.

(4) Legible photocopies of:

(a) Supporting documentation (i.e., Medicare participation agreement and/or other correspondence from a Medicare fiscal intermediary) that the hospice program is currently certified to participate in Medicare [i.e., it meets all Medicare conditions of participation (42 CFR 418) relative to TRICARE beneficiaries].

(b) Current state license (if applicable), which includes the expiration date and the original issue date of licensure.

NOTE: The contractors have been given discretion in developing their own application forms taking into consideration the above requirements.

b. The certifying authority shall make at least one request for information missing from an application. If the hospice fails to provide the information within 30 days following the date of the request, the application will be denied and returned to the hospice.

c. The certification decision shall be rendered within 14 days of receipt by the certifying authority of a complete application.

d. An applicant shall be notified in writing that it is no longer considered an applicant for certification when a pending incomplete application is not made complete within 30 days of the date of a written notice to the applicant of the deficiencies of the applicant's application, unless the certifying authority has extended the response time for good reason.

e. An applicant shall be notified in writing of the specific reason(s) that certification is not granted.

6. Certification process.

a. Authorization of an applicant as a TRICARE-certified hospice program shall be made only after the certifying authority has verified that:

(1) The information provided in the complete application is true and current.

(2) The applicant complies in all respects with the requirements of 32 CFR 199.

(3) The applicant is not otherwise barred from TRICARE provider status.

(4) The applicant has returned a signed participation agreement.

b. The test of the participation agreement for certified hospice programs appears in Chapter 11, Addendum D. The contractor is not authorized to make any change in the language of this agreement without approval from the Executive Director of TMA or designee. Applicant specific changes to this agreement will not be considered by TMA.

- END -