CHAPTER 11
SECTION 2

HOSPICE REIMBURSEMENT - COVERAGE/BENEFITS

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

Services and supplies reimbursed under hospice benefit.

III. POLICY

A. TRICARE beneficiaries who are terminally ill (that is, life expectancy of six months or less if the terminal illness runs its normal course) will be eligible for the following services and supplies in addition to regular TRICARE benefits:

1. Hospice consultation service. Effective January 1,2005 a beneficiary may receive a hospice consultation service from a physician who is also the medical director or employee of a hospice program if the beneficiary:

a. Has not yet elected hospice coverage.

b. Has not been seen by the physician on a previous occasion.

2. The provision of the consult service shall not count towards the hospice cap amount.

B. TRICARE beneficiaries who are terminally ill (that is, life expectancy of six months or less if the terminal illness runs its normal course) will be eligible for the following services and supplies in lieu of other TRICARE benefits:

1. Physician services furnished by hospice employees or under arrangements with the hospice.

NOTE: Patient care services rendered by an attending physician who is not considered employed by, or under contract with, the hospice are not considered hospice services and are not included in the amount subject to the hospice payment limits as described in Chapter 11, Section 4, paragraph III.A.5. and paragraph III.B.6. The attending physician will bill in his/her own right and be subject to the appropriate allowable charge methodology (refer to Chapter 11, Section 4, paragraph III.A.4.).

2. Nursing care provided by or under the supervision of a registered nurse.

a. The RN must maintain overall nursing management of the patient (e.g., review and evaluation of nursing notes).

b. The actual hands-on care may be provided by an LPN without the RN being physically present.

3. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

4. Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home.

a. Counseling services, including dietary counseling, are provided for the purpose of training the terminally ill patient's family or other care-giver to provide care and to help the patient and those caring for him or her to adjust to the individual's approaching death.

b. Bereavement counseling/therapy, which consists of counseling services provided to the individual's family after the individual's death, is required as part of the overall hospice benefit.

(1) There must be an organized program for the provision of bereavement services under the supervision of a qualified professional.

(2) The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery up to one year following the death of the patient.

NOTE: Although bereavement therapy is an integral part of the hospice concept (i.e., a family-centered, model emphasizing supportive services) and must be made available to the family as a condition for participation it is not reimbursable.

5. Short-term inpatient care, both respite and general, may be provided in Medicare participating hospice inpatient units, hospitals, or skilled nursing facilities.

a. Inpatient Respite Care.

(1) Inpatient respite care is provided when necessary to relieve family members or other persons caring for the individual at home.

(2) Respite care may be provided only on an occasional basis and is limited to no more than five consecutive days at a time.

(3) The necessity and frequency of respite care will be determined by the hospice interdisciplinary group with input from the patient's attending physician and the hospice's medical director.

(4) Respite care is also subject to post-payment medical review by the contractor.

(5) Inpatient respite care is the only type of hospice care that can be provided in the Medicaid (Title XIX) certified nursing facility.

b. General Inpatient Care.

(1) Services must conform to the written plan of care.

(2) Care is required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in a home setting.

6. Medical supplies, including drugs and biologicals.

a. Drugs must be used primarily for the relief of pain and symptom control related to the individual's terminal illness in order to be covered under the hospice program.

b. Medical supplies include those that are part of the written plan of care.

7. Durable medical equipment, as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness and provided for use in the patient's home.

8. Home health aide services furnished by qualified aides, and homemaker services.

a. Coverage.

(1) Personal care services.

(2) Household services to maintain a safe and sanitary environment in areas of the home used by the patient; e.g., changing of beds, light house cleaning and/or laundering.

b. Supervision.

(1) The aide services must be provided under the general supervision of the registered nurse. However, the registered nurse does not have to be physically present while aide services are being rendered.

(2) Home health aide services must be documented in the nursing notes as well as the treatment plan.

(3) A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.

(4) The contractor will assess/evaluate overall RN supervision through the post-payment medical review process.

NOTE: The contractors will be looking for utilization trends on random samples of claims. A pattern of failure to adequately meet the supervisory requirements for home health aide services (refer to paragraph III.B.8., above) will result in denial or reclassification of the particular rate category.

9. Physical therapy, occupational therapy and speech-language pathology services for the purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

C. The hospice must ensure that substantially all the following core services are routinely provided directly by hospice employees or provided under an "Authorized use of Arrangements". Effective December 3, 2003, under "Authorized use of Arrangements" the primary hospice may enter into a contract arrangement with another hospice to provide core services under extraordinary, exigent or other non-routine (i.e., high patient load, staffing shortages due to illness) circumstances. The primary hospice may now bill the TRICARE program. However, TRICARE payments for core services remain limited to and reimbursed at one of the four nationally predetermined Medicare rates. Core services consist of:

1. Physician services;

2. Nursing care;

3. Medical social services; and

4. Counseling service for individuals and care givers.

NOTE: Counseling services may be provided by a member of the interdisciplinary group (doctor of medicine or osteopathy, registered nurse, social worker, and pastoral or other counselor) as well as by other qualified professionals as determined by the hospice.

D. Although the following non-core services may be provided under arrangement with other agencies or organizations, the hospice must maintain professional management of the patient at all times and in all settings:

1. Home health aide services;

2. Medical appliances and supplies;

3. Physical and occupational therapy;

4. Speech-language pathology;

5. Short-term inpatient care; and

6. Ambulance services.

NOTE: If contracting is used, the hospice must maintain professional financial, and administrative responsibility for the services and must assure that the qualifications of staff and services provided meet the requirements specified in this policy. The requirements that a hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling be available on a 24-hour basis may be waived if granted by the Centers for Medicare and Medicaid Services (CMS). These waivers are available only to an agency or organization that is located in an area which is not an urbanized area and can demonstrate that it has been unable, despite diligent efforts, to recruit appropriate personnel.

Physical therapy, occupational therapy and speech-language pathology services are included as part of the treatment plan of the interdisciplinary group (a member of which is a doctor of medicine or osteopathy). Medical review of these services will occur as part of the post-payment medical review process.

E. The hospice must make nursing services, physician services, and drugs and biologicals routinely available on a 24-hour basis. All other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for are that is reasonable and necessary for the palliation and management of the terminal illness and related condition.

F. Hospice services must be provided in a manner consistent with accepted standards of practice.

G. Twenty-four-hour nursing and home health aide services may be provided only during periods of crisis and then only as necessary to maintain the terminally ill individual at home.

NOTE: A period of crisis is defined as the time a patient requires continuous care to achieve palliation or management of acute medical symptoms.

H. The hospice benefit is exempt from those limitations on custodial care and personal comfort items applicable to the Basic Program.

I. All services, medical appliances, and supplies associated with the palliative care of the terminal patient is included within the hospice rate with the exception of hands-on physician services (both hospice based and independent attending physicians).

1. The hospice will be responsible for providing medical appliances -- which includes covered durable medical equipment (e.g., hospital bed, wheelchair, etc.) as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness -- for use in the patient's home while he or she is under hospice care. The use of this equipment is included in the daily hospice rate.

2. Parental and enteral nutrition therapies would be covered under the daily hospice rate if determined to be essential for the palliative care of the terminal patient; however, these

types of therapies will be relatively rare in a hospice setting since they are considered life sustaining treatment modalities.

J. Any other item or service which is specified in the treatment plan and for which payment may otherwise be made is a covered service under the hospice benefit.

EXAMPLE: A hospice determines that a patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the treatment plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

K. If a hospice furnishes, at the request of a beneficiary, items or services in addition to those that are covered under the hospice benefit, the hospice may charge the beneficiary for these items or services.

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