CHAPTER 11
SECTION 1

HOSPICE REIMBURSEMENT - GENERAL OVERVIEW

ISSUE DATE: February 6, 1995
AUTHORITY: 32 CFR 199.4(e)(19); 32 CFR 199.6(b)(4)(viii); and 32 CFR 199.14(g)

I. APPLICABILITY

This policy is mandatory for reimbursement of services provided either by 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

A general overview of the coverage and reimbursement of hospice care.

III. POLICY

A. Statutory Background

The Defense Authorization Act for FY 1992-1993, Pub. L. 102-190, directed TRICARE to provide hospice care in the manner and under the conditions provided in section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)). This section of the Social Security Act sets forth coverage/benefit guidelines, along with certification criteria for participation in a hospice program. Since it was Congress' specific intent to establish a benefit identical to that of Medicare, the program has adopted the provisions currently set out in Medicare's hospice coverage/benefit guidelines, reimbursement methodologies (including national hospice rates and wage indices), and certification criteria for participation in the hospice program (42 CFR 418, Hospice Care).

B. Scope of Coverage

The hospice benefit is designed to provide palliative care to individuals with prognoses of less than 6 month to live if the terminal illness runs its normal course. The benefit is based upon a patient and family-centered model where the views of the patient and family or friends figure predominantly in the care decisions. Since this type of care emphasizes supportive services, such as pain control and home care, rather than cure-oriented treatment, the hospice benefit is exempt from those limitations on custodial care and personal comfort items currently in force under the Basic Program. As a result, a beneficiary who elects to receive care under a hospice program cannot receive other Basic Program services/benefits (curative treatment related to the terminal illness unless the hospice care

has been formally revoked.

C. Reimbursement

1. National Medicare hospice rates will be used for reimbursement of each of the following levels of care provided by, or under arrangement with, a Medicare-approved hospice program:

a. Routine home care.

b. Continuous home care.

c. Inpatient respite care.

d. General inpatient care.

2. The hospice will be reimbursed for the amount applicable to the type and intensity of the services furnished to the beneficiary on a particular day. One rate will be paid for each level of care except for continuous home care which will be reimbursed based on the number of hours of continuous care furnished to the beneficiary on a given day. The rates will be adjusted for regional differences by using appropriate Medicare area wage indices.

3. The national payment rates are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice. The only amounts which will be allowed outside the locally adjusted national payment rates will be for direct patient care services rendered by either an independent attending physician or physician employed by, or under contract with, the hospice program.

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

(1) Has not yet elected the hospice benefit at the time of consultation.

(2) Has not been seen by the physician on a previous occasion.

Such consult shall be paid at the appropriate level and shall be equal or less in equivalent reimbursement for a doctor office visit by a patient presenting a problem of "moderate severity and requiring medical decision making of low complexity" under the TRICARE physician fee schedule and will exclude the practice expense component. The receipt and payment of such service shall not count toward the hospice cap amount.

b. The hospice will bill for its physician charges/services on a UB92 using the appropriate CPT codes. Payments for hospice based physician services will be paid at 100 percent of the allowable charge (CMAC) and will be subject to the hospice cap amount; i.e., it will be figured into the total hospice payments made during the cap period.

C. Independent attending physician services are not considered a part of the hospice benefit and are not figured into the cap amount calculations. The provider will bill for these services on a CMS 1500 (08/05) using the appropriate CPT codes. These services will be subject to standard TRICARE reimbursement and cost-sharing/deductible provisions.

D. Authorized Providers

1. Social workers, hospice counselors, and home health aides which are not otherwise authorized providers of care under Basic Program may provide those services necessary for the palliation or management of terminally ill patients electing hospice coverage. These services are part of a package of services for which there is single all-inclusive rate for each day of care.

2. Hospice programs must be Medicare certified and meet all Medicare conditions of participation (42 CFR 418) in relation to patients in order to receive payment under the TRICARE program.

NOTE: The hospice program will be responsible for assuring that the individuals rendering hospice services meet the qualification standards specified in Section 2. The contractor will not be responsible for certification of individuals employed by or contracted with a hospice program.

E. Implementing Instructions

Since this issuance only deals with a general overview of the hospice benefit the following cross referencing is provided to facilitate access to specific implementing instructions within Sections 1 through 4:

IMPLEMENTING INSTRUCTIONS/SECTION
General Overview/Chapter 11, Section 1
Coverage/Benefits/Chapter 11, Section 2
Core Services Non-Core Services Continuous Care Short-term Inpatient Care Counseling Services
Conditions for Coverage/Chapter 11, Section 3
Election Process Certification Process Treatment Plan Requirements Provider Certification Participation Agreement

IMPLEMENTING INSTRUCTIONS/SECTION (CONTINUED)
Reimbursement/Chapter 11, Section 4
Levels of Care Reimbursement Methodology Examples of Reimbursement Payment of Physicians Voluntary Services Cap Amount Inpatient Limitation Administrative Review Hospice Reporting Requirement Limited Cost-Sharing Criteria for Medical Review
Rate Information
National Rates Cap Amount
for FY 2005 (Chapter 11, Addendum A (FY 2005)) for FY 2006 (Chapter 11, Addendum A (FY 2006)) for FY 2007 (Chapter 11, Addendum A (FY 2007))
Urban Wage Indexes
for FY 2005 (Chapter 11, Addendum B (FY 2005)) for FY 2006 (Chapter 11, Addendum B (FY 2006)) for FY 2007 (Chapter 11, Addendum B (FY 2007))
Rural Wage Indexes
for FY 2005 (Chapter 11, Addendum C (FY 2005)) for FY 2006 (Chapter 11, Addendum C (FY 2006)) for FY 2007 (Chapter 11, Addendum C (FY 2007))
Crosswalk Of Counties By States
for FY 2006 (Chapter 11, Addendum D (FY 2006))
Certification Documents
Participation Agreement (Chapter 11, Addendum E)

IV. EFFECTIVE DATE

Implementation of the hospice program is effective for admissions occurring on or after June 1, 1995. Unless specified differently in sections of this instruction, this is to be considered the effective date for reimbursement of hospice care.

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