Chapter 11 Section 3

Hospice Reimbursement - Conditions For Coverage

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1.0 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 the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

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

3.0 POLICY

The following conditions/criteria shall be met in order to receive reimbursement for hospice benefits.

3.1 Pre-Election

Hospice Consultation Service. A beneficiary is able to receive a hospice consult, from a physician who is also the director or employee of a hospice if the beneficiary:

- Has not elected hospice coverage at the time of consultation.
- Has not seen the physician on a previous occasion.

3.2 Election Process

3.2.1 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 shall file the election statement.

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

- Two initial 90-day periods; and
- An unlimited number of subsequent 60-day periods.

3.2.1.2 Only two 90 day periods are allowed during the beneficiary's lifetime. However, there is no limit on 60 day periods as long as the beneficiary meets the requirements for the hospice benefit.

Note: Beneficiaries under the age of 21 who are receiving concurrent hospice services and curative care shall be exempt from this requirement, as detailed in Section 5.

3.2.1.3 These episodes of care shall be used consecutively; that is, the two 90-day periods shall 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 shall 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 the standard program benefits during these gaps in time between election periods.

3.2.1.4 The initial election shall 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 shall query the Defense Enrollment Eligibility Reporting System (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 shall be initiated once a distinct/separate election has been made for a subsequent episode of hospice care.

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

3.2.1.6 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.

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

- A signed statement that the individual revokes the election for coverage of hospice care for the remainder of the election period; and
- The date that the revocation is to be effective.

3.2.1.6.2 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.

3.2.1.7 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.

3.2.1.7.1 The statement shall include the following information:

- The name of the hospice from which the individual has received care;
- The name of the hospice from which the patient plans to receive the care; and
- The date the change is effective.

3.2.1.7.2 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.

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

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

3.2.1.8.2 Other standard 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:

- Provided by the designated hospice;
- Provided by another hospice under arrangements made by the designated hospice; and
- 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.

Note: Beneficiaries under the age of 21 who are receiving concurrent hospice services and curative care are exempt from this requirement, as detailed in Section 5.

3.2.1.9 Basic program coverage shall be reinstated upon revocation of the hospice election.

3.2.1.10 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 non-hospice reimbursement.

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

3.2.1.10.2 The contractor shall identify and review all non-hospice inpatient claims for beneficiaries who have elected hospice care to make sure that:

- For non-related hospital admissions, non-hospice coverage is provided to a

beneficiary only when hospitalization was for a condition not related to his or her terminal illness; and

- 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.

3.2.1.10.3 The distinction between services related to, and not related to, the treatment of the terminal condition for which hospice care was elected and provided during a hospice election shall no longer be a consideration for payment of services provided to beneficiaries under the age of 21, since both types of services may be billed to the contractor for non-hospice reimbursement. As a result, the contractor shall no longer be responsible for identifying and reviewing inpatient claims for beneficiaries under the age of 21 who have elected hospice care to make sure the services were not related to the beneficiary's terminal illness. Contractors shall continue to ensure that duplicate claims are rejected. Requirements for concurrent hospice services and curative care are detailed in Section 5.

3.2.1.11 The beneficiary may receive inpatient hospice care (both general and respite) in a Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) without revocation of an election as long as the following conditions are met:

3.2.1.11.1 The attending MTF/eMSM 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.

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

3.2.1.11.3 The MTF/eMSM inpatient care is strictly palliative in nature and in keeping with the overall hospice treatment plan.

3.2.2 Election Statements

3.2.2.1 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:

3.2.2.1.1 Identification of the particular hospice that will provide care to the individual;

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

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

3.2.2.1.4 Effective date of election; and

3.2.2.1.5 Signature of the individual or representative.

3.2.2.2 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.

3.2.2.3 The hospice representative must make sure that the required election statement is in the clinical records before signing the Notice of Admission (the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 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.

3.2.3 Contractor Notification.

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

3.2.3.1 Notice of Election (NOE). The Form CMS 1450 UB-04, Uniformed Institutional Billing Form, will be used as an admission and election notice.

3.2.3.1.1 When a beneficiary is admitted for hospice services, only Items 1, 4, 5, 8, 9, 10, 11, 12, 45 line 23, 58, 60, 67, 76, and 78 must be completed by the hospice for which the beneficiary has elected to receive care.

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

Note: Since the contractor shall be responsible for providing all health care to beneficiaries residing within its contract area, election information should be submitted to the 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 contractor rather than the contractor having regional jurisdiction.

3.2.3.1.3 The NOE must be submitted to and accepted by the contractor within five calendar days after the hospice election. If the NOE is not submitted within the required five-day interval, TRICARE payment will not be extended for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the contractor. The hospice will be liable for these days and will not bill the beneficiary for them. There are, however, four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than five calendar days after the effective date of election. These exceptional circumstances are as follows:

3.2.3.1.3.1 Fires, floods, earthquakes, or other unusual events that cause extensive damage to the hospice's ability to operate;

3.2.3.1.3.2 An event that produces a data filing problem due to a TRICARE or contractor system issue that is beyond the control of the hospice;

3.2.3.1.3.3 A newly TRICARE-authorized hospice that is notified of authorization after the authorization date; or,

3.2.3.1.3.4 Other circumstances determined by the contractor to be beyond the control of the hospice.

Note: If one of the four circumstances described above prevents a hospice from timely filing its NOE, the hospice must document the circumstances to support a request for an exception, which would waive the consequences of filing the NOE late. The contractor will use this submitted documentation to determine if a circumstance encountered by a hospice qualifies for an exception to the NOE filing deadline.

3.2.3.1.4 The information may be forwarded by mail, electronic means, or telephone depending upon the facility's arrangement with the contractor.

3.2.3.1.5 The following are detailed instructions for completing the admission notice (CMS 1450 UB-04):

- **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 (TOB) Required.** Enter the three digit TOB code: 81A or 82A as appropriate.

- **Code Structure**

  First Digit - Type of Facility
  8 - Special (Hospice)
  Second Digit - Classification (Special Facility)
  1 - Hospice (Non-Hospital-Based)
  2 - Hospice (Hospital-Based)
  Third 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 CMS 1450 UB-04.

- **Item 5. Federal Tax Number.** Enter Tax Identification Number (TIN) or Employer Identification Number (EIN) and the sub-identifier assigned by the contractor.

- **Item 8. Patient's Name Required.** Show the patient's name with the surname first, first name, and middle initial, if any.

- **Item 9. Patient's Address Required.** Show the patient's full mailing address including street name and number or RFD, city, state, and zip code.

- **Item 10. 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 11. Patient's Sex Required.** Show and "M" for male or an "F" for female.

- **Item 12. 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 two calendar days.

- **Item 38. Transferring Hospice ID 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 the ID card. If the TRICARE Program is primary, enter the sponsor's name as recorded on the ID card, in line 58A.

- **Item 60A, B, C. Certificate/Social Security Number (SSN)/Health Insurance Claim/Identification Number.** If primary payer(s) is other than the TRICARE Program, 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 SSN in line 60B or 60C if the patient; or enter the DoD Benefits Number (DBN) in line 60B or 60C if a North Atlantic Treaty Organization (NATO)/Partnership for Peace (PfP) beneficiary.

- **Item 67. Principle Diagnosis Code Required.** For services provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, show the full International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code. For services provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, show the full ICD-10-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 76. Attending Physician ID 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 78. Other Physician ID Required.** Enter the word "employee" or "non-employee" here to describe the relationship that the patient's attending physician has with the hospice program.

- **Items 85 and 86. Provider Representative Signature and Date Required.** Deleted from UB-04, see FL 45, line 23. A hospice representative makes sure that the required physician's certification and a signed hospice election statement are in

the records.

3.2.3.2 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 the TRICARE Program.

3.2.3.3 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.

3.2.3.3.1 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).

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

3.2.3.4 Revocation of Election

3.2.3.4.1 Upon discharge or revocation of hospice care, the beneficiary immediately resumes the TRICARE coverage that had previously been waived by the hospice election. As such, hospices should record the beneficiary's discharge or revocation in the claims processing system promptly.

3.2.3.4.2 If a hospice beneficiary is discharged alive or revokes the election of care, the hospice shall submit a Notice of Termination/Revocation (NOTR) to the contractor within five calendar days after the effective date of discharge or revocation unless the hospice has already filed a final claim. Hospices continue to have 12 months from the date of service in which to file their claims.

3.2.3.4.3 The NOTR will be conveyed to the contractor through item 31 of the CMS 1450 UB-04.

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 election, or death. Show Termination Code 42 in Item 32.

3.2.4 Monitoring of Elections

3.2.4.1 The contractor shall develop and maintain a screen for the tracking of elections made by beneficiaries. The screen shall include:

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

3.2.4.1.2 The inclusive dates for which hospice care will be covered; and

3.2.4.1.3 Revocations and transfers between hospice programs.

3.2.4.2 The above information will be reported to the contractors by use of the CMS 1450 UB-04 (for both Admission Notice and billing).

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

3.2.4.4 An election must be on file 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.

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

3.3 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.

3.3.1 Timing of Certification. The hospice must obtain written certification of terminal illness for each of the election periods described in paragraph 3.2.1, even if a single election continues in effect for two, three or four periods.

3.3.1.1 Physician certification continues to be required no later than two 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.

3.3.1.2 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.

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

3.3.2.1 For the initial 90-day period, the hospice must obtain certification as prescribed in paragraph 3.3 from:

3.3.2.1.1 The individual's attending physician if the individual has an attending physician; and

3.3.2.1.2 The medical director of the hospice or the physician member of the hospice interdisciplinary group.

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

3.3.3 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.

3.3.4 Face-to-face encounter. For recertifications, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of the terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

3.3.4.1 The following criteria must be met in order to satisfy the face-to-face encounter requirement:

3.3.4.1.1 The encounter must occur prior to the recertification for the third benefit period and each subsequent benefit period. The encounter must occur no more than 30 calendar days before the third benefit period recertification and each subsequent certification. A face-to-face encounter may occur on the first day of the benefit period and still be considered timely.

3.3.4.1.2 A hospice physician or a hospice nurse practitioner can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A hospice nurse practitioner must be employed by the hospice. Physician Assistants (PAs), clinical nurse specialists, and outside attending physicians are not authorized to perform the face-to-face encounter for recertification.

3.3.4.1.3 A hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed must be a separate and distinct section of, or an addendum to, the recertification form. Where a nurse practitioner or non-certifying hospice physician performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of 6 months or less should the illness run its normal course.

3.3.4.1.4 In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. In such documented cases, a face-to-face encounter which occurs within two days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

3.3.4.2 Recertifications that require a face-to-face encounter but are missing the encounter are not complete. Where the only reason the patient ceases to be eligible for the TRICARE hospice benefit is the hospice's failure to meet the face-to-face encounter requirement, TRICARE would expect the hospice to discharge the patient from the TRICARE hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish TRICARE eligibility.

3.3.4.3 The hospice can re-admit the patient to the TRICARE hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient files an election statement in accordance with TRICARE regulations.

3.3.5 The hospice representative must make sure that the physician's certification is obtained prior to signing the Notice of Admission (the CMS 1450 UB-04 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.

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

3.4 Treatment Plan

3.4.1 In establishing the initial Plan of Care (POC) the member of the basic interdisciplinary group who assesses the patient's needs shall meet or call at least one other group member (nurse, physician, Medical Social Worker (MSW), or counselor) before writing the initial POC.

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

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

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

3.4.5 A meeting of group members is not required within this two-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 shall ensure that they are furnished in a safe and effective manner by qualified persons.

3.4.6 Hospice services shall be consistent with the POC for coverage to be extended.

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

3.4.8 The hospice shall designate a Registered Nurse (RN) to coordinate the implementation of the POC for each patient.

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

3.4.10 Additional treatment plan requirements for beneficiaries under the age of 21 receiving concurrent hospice services and curative care are detailed in Section 5.

3.5 Medical Review Process

3.5.1 The contractor shall be required to request and review medical records (post-payment medical review), including the written POC, to assure the services were:

- Covered hospice services;
- Stipulated in the plan(s) of care;
- Necessary for the palliation or management of the beneficiary's terminal illness; and
- Appropriately classified for payment purposes.

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

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

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

3.5.4 Additional medical review process requirements for beneficiaries under the age of 21 receiving concurrent hospice services and curative care are detailed in Section 5.

3.6 Provider Certification

3.6.1 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:

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

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

3.6.1.3 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:

3.6.1.3.1 Routinely supply a substantial amount of the nursing and physician services, medical supplies and appliances, discharge planning, and counseling services for the patient and his or her family.

3.6.1.3.2 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.

3.6.1.3.3 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% of the aggregate number of hospice days of care during the same period.

3.6.1.3.4 Have an interdisciplinary group composed of the following personnel who provide the care and services described in Section 2 and establish the policies governing the provision of such care/ services:

- A physician;
- A RN;
- A social worker; and
- A pastoral or other counselor.

3.6.1.3.5 Maintain central clinical records on all patients.

3.6.1.3.6 May utilize volunteers.

3.6.1.3.7 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.

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

3.6.2.1 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.

3.6.2.2 Be allowed to charge the beneficiary for items or services 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 the TRICARE Program when the beneficiary or family representative has been informed that the service/supply is not a TRICARE Program hospice benefit.

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

3.6.2.4 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.

3.6.3 The TRICARE Program 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.

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

3.6.4.1 The senior contractor official for TRICARE Program business shall notify the DHA in writing of the appointment and removal of each person designated by the contractor to sign a hospice participation agreement.

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

3.6.4.3 No more than two individuals shall be so authorized by the contractor concurrently, and the effective date of appointment shall be no earlier than the date of the written notice of appointment DHA.

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 DHA.

3.6.5 Application

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

3.6.5.1.1 The complete name and address of the applicant.

3.6.5.1.2 The EIN.

3.6.5.1.3 Routine and emergency phone numbers for the applicant.

3.6.5.1.4 Legible photocopies of:

3.6.5.1.4.1 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].

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

Note: The contractor shall have discretion in developing their own application forms taking into consideration the above requirements.

3.6.5.2 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.

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

3.6.5.4 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.

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

3.6.6 Certification Process

3.6.6.1 Authorization of an applicant as a TRICARE Program authorized hospice program shall be made only after the certifying authority has verified that:

- The information provided in the complete application is true and current.
- The applicant complies in all respects with the requirements of 32 CFR 199.
- The applicant is not otherwise barred from TRICARE provider status.
- The applicant has returned a signed participation agreement.

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

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