Chapter Chapter 11 Section 4

Hospice Reimbursement - Guidelines For Payment Of Designated Levels Of Care

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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 TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

2.0 ISSUE

To establish procedural guidelines for reimbursement of hospice care.

3.0 POLICY

3.1 Hospice Program Reimbursement

Hospice care will be reimbursed at one of four predetermined national Medicare rates (refer to the tables in Addendums B (urban) and C (rural) based on the type and intensity of services furnished to the beneficiary. The labor-related portions of each of these rates are adjusted by the wage index applicable to the hospice program providing the care (refer to paragraph 3.1.2, for further explanation.) A single rate is applicable for each day of care except for continuous home care where payment is based on the number of hours of care furnished during a 24-hour period.

3.1.1 Levels Of Reimbursement

TRICARE will use the national Medicare hospice rates for reimbursement of each of the following levels of care provided by or under arrangement with an approved hospice program:

3.1.1.1 Routine Home Care

The hospice will be paid for routine home care for each day the patient is at home, under the care of the hospice, and not receiving continuous care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. Payment for routine home care (i.e., revenue code 651) will be based on the geographic location at which the service is furnished as opposed to the location of the hospice.

Example: TRICARE reimbursement for 30 days of routine home care from January 1, 1995, through January 30, 1995 in Chicago, Illinois.

Wage Component Subject to Index	x	Index for Chicago	=	Adjusted Wage Component				
$62.19	x	1.2196	=	$75.85				
Adjusted Wage Component	+	Nonwage Component	=	Adjusted Rate	x	30 days Home Care	=	Routine Rate
$75.85	+	$28.32	=	$104.17	x	30	=	$3,125.10

3.1.1.2 Continuous Home Care

The hospice will be paid the continuous home care rate when continuous home care is provided. Payment for continuous care (i.e., revenue code 652) will be based on the geographic location at which the service is furnished as opposed of the location of the hospice. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. The following provisions are used for payment of this level of care:

3.1.1.2.1 A minimum of eight hours of care must be provided within a 24-hour period, starting and ending at midnight. If less than eight hours of care are provided within a 24-hour period, the care will be paid at the lower routine home care rate.

3.1.1.2.2 More than half of the continuous home care must be provided by either a registered nurse (RN) or licensed practical nurse (LPN); i.e., a RN or LPN must provide more than one-half of the total hours being billed for each 24-hour period.

3.1.1.2.3 Homemaker and home health aide services may be provided to supplement the nursing care to enable the beneficiary to remain at home.

3.1.1.2.4 For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours per day. A part of an hour will be rounded to a whole hour for each hour of continuous care during a 24-hour period.

Example: TRICARE reimbursement for 10 hours of continuous home care provided on December 15, 2006, in Denver, Colorado:

National Rate		Wage Component Subject to Index	x	Index for Denver	=	Adjusted Wage Component
$528.30		$362.99	x	1.2141	=	$440.71
Adjusted Wage Component	+	Nonwage/ 24 Hour Component	x	Hours of Care	=	Hospice Rate
($440.71	+	$165.31) / 24 hr	x	10	=	$252.50

The continuous home care rate of $252.50 was figured by dividing the adjusted rate (i.e., the adjusted wage component plus nonwage component) by 24 hours and multiplying that amount by the actual number of hours rendered.

3.1.1.2.5 In situations where accumulative hours cannot be associated with specific dates of service and the average number of hours per day is equal to or greater than eight hours it can be assumed that the eight hour minimum has been met for each of the dates of service for continuous home care.

Example: A hospice billed for 24 hours of continuous home care over a four day period. Since the average number of hours was less than eight hours per day (24 hours divided by four days equals six hours per day), development would be required. If the number of hours had been 32 hours or more it could have been assumed that the beneficiary had received eight or more hours for each day of continuous home care billed on the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04.

Note: Reimbursement can be extended for routine and continuous hospice care provided to beneficiaries residing in a nursing home facility, that is, physician, nurse, social worker, and home health aide visits to patients requiring palliative care for a terminal illness. TRICARE will not pay for the room and board charges of the nursing home.

3.1.1.3 Inpatient Respite Care

The hospice will be paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for inpatient respite care (revenue code 655) will be based on the geographic location of the hospice.

3.1.1.3.1 Payment for respite care may be made for a maximum of five days at a time, including the date of admission but not counting the date of discharge.

3.1.1.3.2 Payment for the sixth and any subsequent days is to be made at the routine home care rate.

Example: TRICARE reimbursement for 12 days of inpatient respite care provided on March 10, 1995, through March 21, 1995 in Cheyenne, Wyoming:

Respite Rate (Five days)

Wage Component Subject to Index	x	Index for Cheyenne	=	Adjusted Wage Component				
$50.68	x	0.9565	=	$48.48				
Adjusted Wage Component	+	Nonwage Component	=	Adjusted Rate	x	5 days Maximum	=	Routine Rate
$75.85	+	$42.95	=	$91.43	x	5	=	$457.15

Routine Home Care Rate (Seven days)

Wage Component Subject to Index	x	Index for Cheyenne	=	Adjusted Wage Component				
$62.19	x	0.9565	=	$59.49				
Adjusted Wage Component	+	Nonwage Component	=	Adjusted Rate	x	7 days Maximum	=	Routine Rate
$59.49	+	$28.32	=	$87.81	x	7	=	$614.67

TRICARE Payment for Respite Care

Respite Rate for 5 days	+	Routine Home Care Rate for 7 days	=	Payment for 12 days of Respite Care
$457.15	+	$614.67	=	$1,071.82

Since respite care is limited to a maximum of five days, the remaining seven days were figured using the routine home care rate. The payment amounts for both respite and routine home care were combined to establish a payment amount for the 12 days of inpatient care.

Note: Respite care can only be provided on an occasional basis and then only if it is part of the overall treatment plan. The interdisciplinary treatment group has the responsibility of determining the appropriateness and frequency of respite care. Only those respite days which are actually paid at the inpatient respite rate will be counted toward the inpatient limitation; e.g., a respite stay of 15 days will only be reimbursed for five days of inpatient respite care, and as such, only those five days will be counted toward the inpatient limitation.

3.1.1.4 General Inpatient Care

Payment at the inpatient rate will be made when general inpatient care is provided. None of the other fixed payment rates (i.e., routine home care) will be applicable for a day on which the patient receives general inpatient care except on the date of discharge. Payment for general inpatient care (revenue code 656) will be based on the geographic location of the hospice.

Example: TRICARE reimbursement for 15 days of general inpatient care from December 15, 1994, through December 29, 1994, in Las Cruces, New Mexico.

Wage Component Subject to Index	x	Index for Las Cruces	=	Adjusted Wage Component
$257.75	x	0.9417	=	$242.72

Adjusted Wage Component	+	Nonwage Component	=	Adjusted Rate	x	15 General Inpatient Care	=	Routine Rate
$242.72	+	$144.92	=	$387.64	x	15	=	$5,814.60

3.1.2 Area Wage Adjustment

An area wage index will be applied to the wage portion of the applicable national hospice rate for each day of care.

3.1.2.1 Area wage indexes to be used in the calculation of hospice rates for care/services.

3.1.2.1.1 Wage indexes in Addendum B (urban), will be used in the adjustment of rates for hospice programs located within designated urban areas.

3.1.2.1.2 Wage indexes in Addendum C (rural), will be used in the adjustment of rates for hospice programs located within designated rural areas.

Note: The above Medicare area wage adjustments are reflected in each of the rate calculation examples under levels of reimbursement (refer to paragraph 3.1.1) The wage index factors which are to be used for hospice care (Addendums B (urban) and C (rural)) are different than those being used for DRGs and mental health per diems. These wage index factors have been in use since the inception of the Medicare hospice benefit in 1983.

3.1.3 Date of Discharge

For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

3.1.4 Physician Reimbursement

Payment is dependent on the physician's relationship with both the beneficiary and the hospice program.

3.1.4.1 Physicians Employed By, or Contracted With, the Hospice

3.1.4.1.1 Administrative and supervisory activities (i.e., establishment, review and updating of plans of care, supervising care and services, and establishing governing policies) are included in the adjusted national payment rate.

3.1.4.1.2 Direct patient care services are paid in addition to the adjusted national payment rate.

- Physician services will be reimbursed an amount equivalent to 100% of the TRICARE allowable charge; i.e., hospice-based physician services (direct hands-on care) are not subject to standard TRICARE cost-sharing and deductible provisions.

- Physician payments will be counted toward the hospice cap limitation.

3.1.4.2 Individual Attending Physician

Patient care services rendered by an individual attending physician (a physician who is not considered employed by, or under contract with, the hospice) are not part of the hospice benefit.

3.1.4.2.1 Reimbursement of Services

3.1.4.2.1.1 Attending physician may bill in his/her own right.

3.1.4.2.1.2 The definition of attending physician, effective December 2003, is expanded to include nurse practitioner (NP) for patient care services. The NP may not certify the beneficiary as terminally ill.

3.1.4.2.1.3 Services will be subject to the appropriate allowable charge methodology.

3.1.4.2.1.4 Reimbursement is not counted toward the cap limitation.

3.1.4.2.2 Coordination of Services

3.1.4.2.2.1 Services provided by an individual attending physician must be coordinated with any direct care services provided by hospice physicians. This coordination will be assessed as part of the post-payment medical review process.

3.1.4.2.2.2 The hospice must notify the contractor of the name of the physician or NP whenever the attending physician is not a hospice employee.

Note: The hospice will notify the contractor of the name of the attending physician or NP as part of the information to be supplied on the admission notice (CMS 1450 UB-04). Refer to Items 76 and 77, Section 3. The independent attending physician or NP is the only outside provider that may provide care to the hospice patient. The contractor will not be expected to monitor this billing, since it is submitted independently of the hospice.

3.1.4.3 Voluntary Services

No payment will be allowed for physician services furnished voluntarily (both physicians employed by and under contract with the hospice and individual attending physicians). Physicians may not discriminate against beneficiaries; e.g., designate all services rendered to non-TRICARE patients as volunteer and at the same time bill for TRICARE patients.

3.1.5 Cap on Overall Reimbursement

Each TRICARE-approved hospice program will be subject to a cap on aggregate TRICARE payments from November 1 through October 31 of each year, hereafter known as "the cap period".

3.1.5.1 Calculation/Application of Cap Amount

The contractor will calculate and apply the cap amount at the end of each cap period using the following guidelines:

3.1.5.1.1 The "cap amount" is calculated by multiplying the number of TRICARE beneficiaries electing hospice care (numbers of beneficiaries electing hospice care during the period beginning September 28 of the previous cap year through September 27 of the current cap year) during the period by a statutory amount determined each year by the CMS.

3.1.5.1.2 The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, the initial cap calculations for newly certified hospices cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1994, would run from October 1, 1994 through October 31, 1995. Similarly, the first cap period for hospice providers entering the program after November 1, 1993 but before November 1, 1994 would end October 31, 1995.

3.1.5.1.3 The aggregate cap amount will be compared with total actual TRICARE payments made during the same cap period.

- "Total payment" refers to payment for services furnished during the cap year

beginning November 1 and ending October 31, regardless of when payment is actually made.

- Payments are measured in terms of **all** payments made to hospices on behalf of **all** TRICARE beneficiaries receiving services during the cap year, regardless of which year the beneficiary is counted in determining the cap (i.e., all TRICARE beneficiaries within a particular hospice program).

- Payments made to a hospice for an individual electing hospice care on October 5, 1994, pertaining to services rendered in the cap year beginning November 1, 1994, and ending October 31, 1995, would be counted as payments made during that cap year (November 1, 1994 - October 31, 1995), even though the individual would not be counted in the calculation of the cap for that year. The individual would, however, be counted in the cap calculation for the following year, because the election occurred after September 27.

3.1.5.1.4 The hospice will be responsible for reporting the number of TRICARE beneficiaries electing hospice care during the "cap period" to the contractor. This must be done within 30 days after the end of the "cap period".

3.1.5.1.5 The cap amount will be adjusted annually by the percent of increase or decrease in the medical expenditure category of the Consumer Price Index for all urban consumers (CPI-U).

3.1.5.1.6 The adjusted cap amount will be obtained by TMA from the CMS prior to the end of each cap period and provided to the contractors.

3.1.5.1.7 Payments in excess of the cap amount must be refunded by the hospice program.

3.1.5.2 Determining Number of Elections

The following rules must be adhered to by the hospice in determining the number of TRICARE beneficiaries who have elected hospice care during the period:

3.1.5.2.1 The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

3.1.5.2.2 The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing TRICARE beneficiary during the current cap year.

3.1.5.2.3 Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included.

3.1.5.2.4 There will be proportional application of the cap amount when a beneficiary elects to receive hospice benefits from two or more different TRICARE-certified hospices. A calculation must be made to determine the percentage of the patient's Length Of Stay (LOS) in each hospice relative to the total length of hospice stay.

3.1.5.2.4.1 The contractor having jurisdiction over the hospice program in which the beneficiary dies or exhausts the hospice benefit will be responsible for determining the proportionate LOS for all preceding hospices.

3.1.5.2.4.2 The contractor will also be responsible for disseminating this information to any other contractors having jurisdiction for hospices in which the beneficiary was previously enrolled.

Note: While it is assumed that crossing of contractor jurisdictional areas (care in hospices located in different jurisdictional areas) will be relatively rare, there is no question that it will occasionally happen. Care in another jurisdictional area can only be detected if it is reported in the admission notice or detected upon retrospective (post payment) medical review; e.g., in the case of a change in election, the second (receiving) hospice will use Item 38 (CMS 1450 UB-04) of the admission notice to indicate the transferring hospice's complete name, address, and provider number. The method of reporting will be left up to the individual contractor. The information should be shared with the other contractors as soon as possible after the demise of the beneficiary so that the other contractors have ample time to adjust the elections used in calculating the hospice's cap amount. The contractor will have to maintain this information for end of the year reconciliation (figuring of cap amounts).

3.1.5.2.4.3 Each contractor will then adjust the number of beneficiaries reported by these hospices based on the latest information at the time the cap is applied.

Example: John Smith, a TRICARE beneficiary, initially elects hospice care from Hospice A on September 2, 1994. Mr. Smith stays in Hospice A until October 2, 1994 (30 days) at which time he changes his election and enters Hospice B. Mr. Smith stays in Hospice B for 70 days until his death on December 11, 1994. The contractor having jurisdiction over Hospice B will be responsible for determining the proportionate number of TRICARE beneficiaries to be reported by each hospice that delivered hospice services to Mr. Smith. This contractor determines that the total length of hospice stay for Mr. Smith is 100 days (30 days in Hospice A and 70 days in Hospice B). Since Mr. Smith was in Hospice A for 30 days, Hospice A should count 0.3 of a TRICARE beneficiary for Mr. Smith in its hospice cap calculation (30 days divided by 100 days). Hospice B should count 0.7 of a TRICARE beneficiary in its cap calculation (70 days divided by 100 days). The contractor servicing Hospice B will make these determinations and notify the contractor servicing Hospice A of its determination. These contractors will then be responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

3.1.5.3 Readjustment of Cap Amount

Readjustment may be required if information previously unavailable to the contractor at the time the hospice cap is applied subsequently becomes available.

Example: Using the previous example, if the contractor servicing Hospice A had calculated and applied the hospice cap on November 30, 1994, information would not have been available at that time to adjust the number of beneficiaries reported by Hospice A, since Mr. Smith did not die until December 11, 1994. The contractor servicing Hospice A would have to recalculate and reapply the hospice cap to Hospice A based on the information it later received from the contractor servicing Hospice B. The cap for

Hospice A after recalculation would then reflect the proper beneficiary count of 0.3 for Mr. Smith.

3.1.5.4 Apportionment of Election Between Cap Years

The following guidelines will be followed when more than one TRICARE-certified hospice provides care to the same individual, and the care overlaps two cap years:

3.1.5.4.1 Each contractor must determine in which cap year the fraction of a beneficiary should be reported.

3.1.5.4.1.1 If the beneficiary entered the hospice before September 28, the fractional beneficiary would be included in the current cap year.

3.1.5.4.1.2 If the beneficiary entered the hospice after September 27, the fractional beneficiary would be included in the following cap year.

Note: Continuing with the case cited in the examples above, Hospice A would include 0.3 of a TRICARE beneficiary in its cap calculation for the cap year beginning November 1, 1994, and ending October 31, 1995, since Mr. Smith entered Hospice A before September 28, 1995. Hospice B would include 0.7 of a TRICARE beneficiary in its cap calculation for the cap year beginning November 1, 1995, and ending October 31, 1996, since Mr. Smith entered hospice B after September 27, 1995.

3.1.5.4.2 Where services are rendered by two different hospices to one TRICARE patient, and one of the hospices is not certified by TRICARE, no proportional application is necessary. The contractor will count one patient and use the total cap for the certified hospice.

3.1.5.5 Hospice Participation at Any Time Other Than Beginning of Cap Year (November 1)

In those situations where a hospice begins participation in TRICARE at any time other than the beginning of a cap year (November 1), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used.

Example: 10/01/1992 - Hospice A is Medicare-certified.

10/01/1992 to 10/31/1993 - First cap period (13 months) for Hospice A.

Statutory cap for first TRICARE cap year (11/01/1992 - 10/31/1993)

Statutory cap for second TRICARE cap year (11/01/1993 - 10/31/1994)

Weighted average cap calculation for Hospice A:

One month (10/01/1993 - 10/31/1993) at $12,248 = $12,248

12 months (11/01/1993 - 10/31/1994) at $12,846 = $154,152

13-month period (rounded) ($12,248 + $154,152) = $166,400 divided by 13 = $12,800

The $12,800 amount is the weighted average cap amount used in the initial cap calculation for Hospice A for the period October 1, 1993 through October 31, 1994.

Note: If Hospice A had been certified in mid-month, a weighted average cap amount based on the number of days falling within each cap period is used.

3.1.6 Inpatient Limitation

Payments for inpatient hospice care are subject to a limitation on the number of days of inpatient care furnished to a TRICARE patient.

3.1.6.1 During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both for general inpatient care and respite care, may not exceed 20% of the aggregate total number of days of hospice care provided to all TRICARE beneficiaries during the same period.

3.1.6.2 The inpatient limitation will be applied once each year, at the end of the hospice's "cap period" (November 1 - October 31).

3.1.6.3 If the contractor (who is responsible for processing the claims) determines that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days.

Note: The accuracy of the billing and the appropriateness of the 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.

3.1.6.4 The inpatient limitation will be calculated by the contractor servicing the hospice as follows:

3.1.6.4.1 The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of TRICARE hospice care by 0.2.

3.1.6.4.2 If the total number of days of inpatient care furnished to TRICARE hospice patients is less than or equal to the maximum, no adjustment will be necessary.

3.1.6.4.3 If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

3.1.6.4.3.1 Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

3.1.6.4.3.2 Multiplying excess inpatient care days by the routine home care rate.

3.1.6.4.3.3 Adding together the amounts calculated in paragraphs 3.1.6.4.3.1 and 3.1.6.4.3.2.

3.1.6.4.3.4 Comparing the amount in paragraph 3.1.6.4.3.3 with interim payments made to the hospice for inpatient care during the "cap period".

3.1.6.4.4 Payments in excess of the inpatient limitation must be refunded by the hospice program.

Example: Serenity Hospice of Seattle, Washington, provided the following information/data on its annual report form (received by contractor on December 1, 1993):

Number of TRICARE beneficiaries electing hospice care during the period from September 28, 1993 through September 27, 1994.	29
Total payment received and receivable for the cap period from November 1, 1993 through October 31, 1994 for services furnished to TRICARE beneficiaries during the cap period.	$202,161.55
Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to TRICARE beneficiaries for the period from November 1, 1993 through October 31, 1994.	$91,354.75
Aggregate number of TRICARE inpatient days for both general inpatient and inpatient respite care for the period of November 1, 1993 through October 31, 1994.	292
Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from November 1, 1993 through October 31, 1994.	1,237

Inpatient Limitation

Step 1: Maximum allowable inpatient days (MAIDs) are calculated by multiplying the total number of days of TRICARE hospice care by 0.2.

Total TRICARE Hospice Days	x	Percent Inpatient Limitation	=	Maximum Allowable Number of Inpatient
1,237 days	x	0.2	=	247.44

Step 2: Since the total number of days (292 days) of inpatient care exceed the maximum allowable number of inpatient days (rounded to 247 days) the limitation will be determined by:

Step 2a: Calculating the ratio of the maximum allowable days to the number of actual days of inpatient care and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement that was made).

Maximum Allowable Inpatient Days / Actual Days of Inpatient Care	x	Total Inpatient Reimbursement	=	Amount (a)
247 days / 292 days	x	$91,854.70	=	$77,699.05

Step 2b: Multiply excess inpatient days by the routine home care rate.

Excess Inpatient Care Days (Actual Days - MAIDs)	x	Routine Home Care Rate for Seattle	=	Amount (b)
(292 days - 245 days) = 45 days	x	$94.02	=	$4,230.90

Step 2c: Add together amounts from Steps 2a and 2b.

Amount (a)	+	Amount (b)	=	Amount (c)
$77,699.05	+	$4,230.90	=	$81,929.95

Step 2d: Compare amount from Step 2c with total TRICARE payments received and receivable for the cap period from November 1, 1993 through October 31, 1994.

Actual TRICARE Payments	-	Amount (c) Above of Inpatient	=	Payments in Excess Limitation
$91,354.75	-	$81,929.95	=	$9,424.80

3.1.7 Notification and Recoupment

The contractors will be responsible for notifying those hospice programs which have been paid in excess of the aggregate cap amount and/or inpatient limitation.

3.1.7.1 The contractors will calculate the cap and inpatient amounts for each TRICARE hospice program and request a refund for those exceeding the calculated amounts.

Note: The contractor will be given discretion in developing its own letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed under paragraph 3.1.10.

3.1.7.2 All refund checks will be sent to the TMA Contract Resource Management (CRM) Directorate.

3.1.7.2.1 If the hospice fails to submit the refund, the contractor will issue two additional demand letters which will be sent out at appropriate intervals as required by the TRICARE Operations Manual (TOM).

3.1.7.2.2 Copies of the demand letters will not be sent to the beneficiary, and providers will not be placed on offset to collect overpayments.

3.1.7.2.3 If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, recoupment cases will be transferred to TMA in compliance with the TOM.

3.1.8 Hospice Reporting Responsibilities

The hospice is responsible for reporting the following data within 30 days after the end of the cap period:

3.1.8.1 Data requirements.

3.1.8.1.1 Total number of TRICARE beneficiaries electing hospice care during the period beginning September 28 of the previous cap year through September 27 of the current cap year.

3.1.8.1.2 Total number of TRICARE hospice days (both inpatient and home care).

3.1.8.1.3 Total reimbursement received and receivable for cap period for services furnished to TRICARE beneficiaries, including employed physician's services not of an administrative and/or general supervisory nature.

3.1.8.1.4 Total reimbursement received and receivable for general inpatient and respite care during cap period.

3.1.8.1.5 Aggregate number of TRICARE inpatient days for both general inpatient care and inpatient respite care during cap period.

3.1.8.1.6 Aggregate number of TRICARE routine days during cap period.

3.1.8.1.7 Aggregate total number of days of hospice care provided to all TRICARE beneficiaries during the cap period.

3.1.8.2 Contractors will be given discretion in designing their own report forms taking into consideration the above data requirements. The following is an example of an acceptable report form:

CAP PERIOD ENDED - October 31, ____

Hospice _____

Provider Number: _____

1. Number of TRICARE beneficiaries electing hospice care during the period from 09/28/____ through 09/27/____. _____

2. Total payment received and receivable for the cap period from 11/01/____ through 10/31/____ for services furnished to TRICARE beneficiaries during the cap period, including employed physician's services not of an administrative and/or general supervisory nature. _____

3. Total reimbursement received and receivable for general inpatient care and inpatient respite care furnished to TRICARE beneficiaries for the period from 11/01/____ through 10/31/____. _____

4. Aggregate number of TRICARE inpatient days for both general inpatient care and inpatient respite care for the period from 11/01/____ through 10/31/____. _____

a. Aggregate number of TRICARE routine days for the period from 11/01/____ through 10/31/____. _____

b. Aggregate number of TRICARE continuous home care hours for the period 11/01/____ through 10/31/____. _____

5. Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from 11/01/____ through 10/31/____. _____

_____ _____
SIGNATURE DATE

_____
TITLE

3.1.9 End of the Year Reconciliation

The contractor will be responsible for calculation of the cap amount and inpatient limitation for each TRICARE approved hospice program within its jurisdictional area.

3.1.9.1 The information/data for calculation of the cap amount and inpatient limitation will come directly off of the data report form which must be submitted to the contractor within 30 days after the end of the cap period (i.e., by December 1st of each year).

3.1.9.1.1 The contractors will not be responsible for validation of this information unless there is a request for reconsideration by one of the hospice programs.

3.1.9.1.2 Adjustments to these end of the year calculations should be minimal since the hospice will be reporting total payments **received** and **receivable** for the cap period.

3.1.9.1.3 Payments for hospital based physicians (billed by the hospice program on the CMS 1450 UB-04) will be subject to the cap amount; i.e., it will be figured into hospice payments made during the cap period.

3.1.9.1.4 Independent attending physician or NP services are not considered a part of the hospice benefit and are not figured into the cap amount calculations. The provider will bill for the services on a CMS 1500 (08/2005) using appropriate Current Procedural Terminology (CPT) codes.

3.1.9.2 The contractor will have 30 days (until January 1st of each year) in which to calculate and apply the cap and inpatient amounts to each TRICARE approved hospice within its jurisdictional area. The contractor will request a refund from those hospice programs found to exceed the calculated amounts.

3.1.9.2.1 The contractor will be given discretion in developing it own recoupment letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed under paragraph 3.1.10.

3.1.9.2.2 Refund checks will be sent to the TMA CRM Directorate. If the hospice fails to submit the refund, the contractor will issue two additional demand letters which will be sent out at appropriate intervals as required by the TOM. Copies of the demand letters will not be sent to the beneficiary, and providers will not be placed on offset to collect overpayments. If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, recoupment cases will be transferred to TMA in compliance with the TOM.

Note: It is anticipated that the number of recoupments will be relatively low based on past Medicare experience; e.g., one Medicare carrier reported that only two hospice programs exceeded the cap and inpatient limitations during the previous cap period (November 1, 1992 through October 31, 1993) in its jurisdictional area.

3.1.10 Reconsideration of Cap Amount and Inpatient Limit

A hospice dissatisfied with the contractor's calculation and application of its cap amount and/or inpatient limitation may request and obtain a contractor review if the amount of program reimbursement in controversy -- with respect to matters which the hospice has a right to review -- is at least $1000. The administrative review by the contractor of the calculation and application of the cap amount and inpatient limitation is the only administrative review available. These calculations are not subject to the appeal procedures set forth in 32 CFR 199.10. A request for reconsideration must be filed no later than (NLT) the 180th calendar days following the date the hospice received notice of the contractor's determination.

Note: The methods and standards for calculation of the hospice payment rates established by TRICARE, as well as questions as to the validity of the applicable law, regulations or TRICARE decisions, are not subject to administrative review (the appeal procedures of 32 CFR 199.10).

3.1.11 Billing Procedures

Completion of the CMS 1450 UB-04 for hospice care. The following is information needed for completion of those items required for the billing of hospice care. Items not listed need not be completed unless otherwise required in double coverage situations.

3.1.11.1 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.

3.1.11.2 Item 4 - Type of Bill (TOB) Required

This three digit code gives three specific pieces of information. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit indicates the sequence of this bill in this particular episode of care (referred to as a "frequency" code).

CODE STRUCTURE	
FIRST DIGIT - TYPE OF FACILITY	
08 - Special (Hospice)	
SECOND DIGIT - CLASSIFICATION	
1 - Hospice (Nonhospital-Based) 2 - Hospice (Hospital-Based)	
THIRD DIGIT - FREQUENCY DEFINITION	
1 - Admit Through Discharge Claim	Use this code for a bill encompassing an entire course of hospice treatment for which you expect reimbursement; i.e., no further bills will be submitted for this patient.

CODE STRUCTURE	
2 - Interim - First Claim	Use this code for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	Use this code when a payment bill for a hospice course of treatment has been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	Use this code for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (Item 6) is the discharge date or date of death.
7 - Replacement of Prior Claim	Use this code to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" code.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. Submit a code "7" (Replacement of Prior Claim) to show the corrected information.

3.1.11.3 Item 5 - Federal Tax Number

Enter tax identification number (TIN) or employer identification number (EIN) and the sub-ID assigned by the contractor.

3.1.11.4 Item 6 - Statement Covers Period (From-Through) Required

Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do not show days before the patient's eligibility began. Since the 12-month hospice "cap period" ends each year on October 31, hospice services for October and November cannot be submitted on the same bill. Use October 31 as a cutoff date. Submit separate bills for October and November.

Note: If the hospice bills for services that cross the cap period split the bill and process the October portions through the cap period cutoff date of October 31. Return the November portion of the bill uncontrolled.

3.1.11.5 Item 12 - Patient's Name Required

Show the patient's name with the surname first, first name, and middle initial, if any.

3.1.11.6 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.

3.1.11.7 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.

3.1.11.8 Item 15 - Patient's Sex Required

Show an "M" for male or an "F" for female.

3.1.11.9 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 two 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 hospice benefit period will end 90 days from January 8, 1994.

Show the month, day, and year numerically as MM-DD-YY.

3.1.11.10 Item 22 - Patient Status Required

This code indicates the patient's status as of the "Through" date of the billing period (Item 6).

CODE STRUCTURE	
01	Discharged (left this hospice)
30	Still patient (remains a patient)
40	Died at home
41	Died in a medical facility, such as a hospital, SNF, or freestanding hospice
42	Place of death unknown

3.1.11.11 Item 32, 33, 34, and 35 - Occurrence Codes and Dates

Show code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use Item 36 (occurrence span) or Item 84 (remarks) to record additional occurrences and dates. Use the following occurrence codes where appropriate:

CODE	TITLE	DEFINITION
24	Date Insurance Denied	This code indicates the date you received the denial of coverage from an insurer other than TRICARE.
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 the termination code 42 in Item 32.

3.1.11.12 Item 38 - Transferring Hospice ID Required

3.1.11.12.1 Only when the admission is for a patient who has changed an election from one hospice to another.

3.1.11.12.2 When a receiving (second) hospice submits an admission notice involving a patient who changed the hospice election, this item reflects the transferring hospice's complete name, address, and provider number. This information alerts the contractor that the admission continues a current hospice benefit period rather than begins a new one.

3.1.11.13 Items 39, 40, and 41 - Value Codes and Amounts

The only value codes that apply to hospice benefits are those that indicate TRICARE payment is secondary to another payer. Enter the appropriate code(s) and related dollar amount(s) where the primary payer is other than TRICARE, and where the primary payer has made payment at the time of billing TRICARE. If the primary payer has denied payment, indicate this with zeros in the value amount. Enter the date of the denial and occurrence code 24 in the appropriate field. The value codes are two numeric digits, and each value allows up to eight numeric digits (000000.00). If more than one value code is shown for a billing period, show codes in ascending numeric sequence. There are four lines of data: a, b, c, and d. Use Items 39a through 41a before Items 39b through 41b (i.e., the first line is used up before the second line is used).

CODE	TITLE	DEFINITION
12	Working Age/Beneficiary/ Spouse with Employer Group Health Plan (EGHP)	This code indicates the amount shown in that portion of a higher priority EGHP payment that you are applying to covered TRICARE charges on this bill.
13	End Stage Renal Disease (ESRD) in the 12-month coordination period with an EGHP	This code indicates the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD beneficiary that you are applying to covered TRICARE charges on the bill.
14	Automobile, No-Fault or Any Liability Insurance	This code indicates the amount shown is that portion of a higher priority automobile, no-fault or liability insurance payment made on behalf of a TRICARE beneficiary you are applying to covered TRICARE charges on this bill.
15	Worker's Compensation (WC) including Black Lung (BL)	This code indicates the amount shown is that portion of a higher priority WC insurance payment made on behalf of a TRICARE beneficiary you are applying to covered TRICARE charges on this bill.
16	Department of Veterans Affairs (DVA), Public Health Service (PHS), Other Federal Agency	This code indicates the amount shown is that portion of a higher priority VA, PHS, or other Federal Agency's payment made on behalf of a TRICARE beneficiary that you are applying to covered TRICARE charges on this bill.

3.1.11.14 Item 42 - Revenue Code Required

3.1.11.14.1 Assign a revenue code for each reimbursement rate. Enter the appropriate three digit numeric revenue code on the adjacent line in column 42 to explain each charge in column 43.

Note: Use revenue code 657 to identify the charges for services furnished to patients by physicians employed by, or receiving compensation from the hospice. In conjunction with revenue code 657, enter the appropriate physician CPT procedure codes in Item 44. CPT procedure codes are required in order that the contractor may make allowable charge determinations when reimbursing hospice physicians.

3.1.11.14.2 Use these revenue codes to bill TRICARE.

CODE	DESCRIPTION	STANDARD ABBREVIATION
651	Routine Home Care	RTN Home
652	Continuous Home Care	CTNS Home (a minimum of 8 hours, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is routine home care for reimbursement purposes. A portion of an hour is 1 hour).
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNL IP
657	Physician Services	PHY Ser (must be accompanied by a physician CPT procedure code)
As of October 1, 1997, hospices will be required to submit claims for payment for hospice care furnished in an individual's home (i.e., revenue codes 651 and 652) based on the geographic location at which the service is furnished as opposed to the location of the hospice. Providers will be required to indicated the Metropolitan Statistical Area (MSA)/rural state code number with value code 61 on the bill. For dates of service beginning on or after October 1, 1997, hospice claims bill types 81X and 82X with revenue codes 651 and 652 that do not contain value code 61 and a MSA code/rural state code will be rejected.		

3.1.11.15 Item 46 - Units of Service Required

Enter the number of units for each type of service on the line adjacent to the revenue code and description. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

3.1.11.16 Item 47 - Total Charges Required

Enter the total charges for the billing period by revenue code (column 42) on the adjacent line in column 47. The last revenue code entered in column 42 represents the grand total of all charges billed. The total is in column 47 on the adjacent line. Each line allows up to eight numeric digits (000000.00).

3.1.11.17 Item 50A, B, C - Payer Identification Required

If TRICARE is the **only insurer** other than Medicaid and TRICARE Supplemental Plans, TRICARE is the primary payer. Enter the correct contractor in line 50A. If there are other insurers besides Medicaid and TRICARE supplemental plans, TRICARE is not the primary payer. Enter the name of the group(s) or plan(s) in line 50A or 50A and 50B. Enter the correct contractor in line 50B or 50C.

3.1.11.18 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. Enter the sponsor's name in line 58B or 58C if TRICARE patient as recorded on ID card. If TRICARE is primary, enter the sponsor's name as recorded on the ID card, in line 58A.

3.1.11.19 Item 60A, B, C - Certificate/Social Security Number (SSN)/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 & 60B. Enter the sponsor's SSN in line 60B or 60C if TRICARE patient; or enter the NATO in line 60B or 60C if a NATO beneficiary.

3.1.11.20 Item 67 - Principal Diagnosis Code Required

For services provided prior to 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 date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**, show the full International Classification of Diseases, 10th Revision, Clinical Modification (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.

3.1.11.21 Item 82 - 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 84 "Remarks" for additional space for recording this information.

3.1.11.22 Item 78 - Other Physician ID Required

Enter the word "employee" or "nonemployee" to describe the relationship that the patient's attending physician has with the hospice program.

3.1.11.23 Item 80 - Remarks

Enter any remarks needed to provide information not shown elsewhere on the bill but which are necessary for proper payment.

3.1.11.24 Items 85 and 86 - Provider Representative Signature and Date

Deleted from UB-04, see FL 45, line 23. A hospice representative makes sure that the required physician's certification and a signed election statement are in the records before submitting the CMS 1450 UB-04.

3.1.12 Special Processing and Reporting Requirements

3.1.12.1 The various levels of hospice care will be considered institutional care for payment and reporting purposes. The special rate code "P" (TRICARE Systems Manual (TSM), Chapter 2, Section 2.8) will be designated for the four levels of hospice care.

3.1.12.2 The conventional coding for hospice care on the CMS 1450 UB-04, Item 4, is a four digit numerical code designating the TOB required.

3.1.12.2.1 For institutional reporting purposes the first two digits will be converted to the appropriate TYPE OF INSTITUTION code provided in the TSM, Chapter 2, Addendum D. Code 81 will be converted to 78 (non-hospital based hospice) and code 82 will be converted to 79 (hospital-based hospice).

3.1.12.2.2 The third digit will be reported on a separate institutional reporting field (FREQUENCY CODE), TSM, Chapter 2, Section 2.5.

3.1.12.3 Type of institution codes 78 and 79 along with the special processing code # (TSM, Chapter 2, Addendum D) will allow hospice institutional claims to by-pass all cost-sharing edits.

3.1.12.4 The revenue code 0657 will be used to identify the charges for services furnished to patients by physicians employed by, or receiving compensation from the hospice.

3.1.12.4.1 Physician procedure codes (CPT procedure codes) will be entered in Item 44 of the CMS 1450 UB-04 to the right of the revenue code 0657 (Item 42). The CPT procedure codes are required in order that the contractor may make allowable charge (CMAC) determinations when reimbursing hospice physicians.

3.1.12.4.2 Hospice professional services will be paid at 100% of the allowed charge.

3.1.12.4.3 Place of service code 34 (TSM, Chapter 2, Section 2.7) along with the special processing code number will allow hospice non-institutional claims (hospice physician charges) to by-pass all cost-sharing edits and to be paid at 100% of the allowed charge (CMAC).

3.1.12.5 Institutional services (i.e., routine home care-651, continuous home care-652, inpatient respite care-655, and general inpatient care-656) will be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT procedure codes) will be reported on an non-institutional claim format. The claim will be split for reporting purposes.

3.1.12.6 Patient care services rendered by an independent attending physician or NP (physician or NP who is not considered employed by, or under contract with the hospice) are not considered a part of the hospice benefit, and as such, will be billed in his/her own right.

3.1.12.6.1 Independent attending physician or NP services will be subject to standard TRICARE allowable charge methodology (i.e., subject to standard deductible and cost-sharing provisions).

3.1.12.6.2 The physician speciality code (TSM, Chapter 2, Addendum C) will be reported on the TED.

3.1.13 Billing for Covered TRICARE Services Unrelated to Hospice Care

3.1.13.1 Any covered TRICARE services not related to the treatment of the terminal condition for which hospice care was elected, which are provided during a hospice period, are billed to the contractor for non-hospice reimbursement.

3.1.13.2 Non-hospice services are billed by the provider in accordance with existing claims processing procedures under the TRICARE Basic program.

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

- Nonrelated hospital admissions, nonhospice TRICARE coverage is provided to a beneficiary only when hospitalization was for a condition not related to his or her terminal illness; and

- 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. The treatment of these related conditions is part of the overall hospice benefit, and as such, cannot be billed under TRICARE standard, except for services of an attending physician who is not employed by, or under contract with, the hospice program.

3.1.14 Frequency of Hospice Billing

While inpatient billing is generally deferred until discharge, hospice programs may bill patient stays requiring longer than 30 days in 30-day intervals. This requirement applies to both the institutional and hospice-based physician claims.

3.1.15 Updated Hospice Rates

- The rates in Addendum A (FY 2010) will be used for payment of claims for services rendered on or after October 1, 2009, through September 30, 2010. The hospice cap amount applies to the cap year ending October 31, 2009.

- The rates in Addendum A (FY 2011) will be used for payment of claims for services rendered on or after October 1, 2010, through September 30, 2011. The hospice cap amount applies to the cap year ending October 31, 2010.

- The rates in Addendum A (FY 2012) will be used for payment of claims for services rendered on or after October 1, 2011, through September 30, 2012. The hospice cap amount applies to the cap year ending October 31, 2011.

3.2 Beneficiary Cost-Sharing

There are no deductibles under the hospice benefit. TRICARE pays the full cost of all covered services for the terminal illness, except for small cost-share amounts which **may be** collected by the individual hospice for outpatient drugs and biologicals and inpatient respite care.

Note: The collection of cost-share amounts are optional under the hospice program.

3.2.1 The patient is responsible for 5% of the cost of outpatient drugs, or $5 toward each prescription, whichever is less. Additionally, the cost of prescription drugs (drugs or biologicals) may not exceed that which a prudent buyer would pay in similar circumstances; that is, a buyer

who refuses to pay more than the going price for an item or service and also seeks to economize by minimizing costs.

3.2.2 For inpatient respite care, the cost-share for each respite care day is equal to 5% of the amount TRICARE has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

Example: Calculation of the cost-share for respite care in Denver, Colorado.

Wage Component Subject to Index	x	Index for Denver	=	Adjusted Wage Component
$50.68	x	1.2141	=	$61.53

Adjusted Wage Component	+	Nonwage Component	=	Adjusted Rate
$61.53	+	$42.95	=	$104.48

Adjusted Rate / 0.95 (Rate to Include Cost-Share	x	% Cost-Share	=	Cost-Share) Amount
$104.48 / 0.95	x	0.05	=	$5.50

3.2.3 The cost-sharing provisions established under paragraph 3.2 are applicable to all beneficiaries regardless of the sponsor's status (active duty or retired).

3.2.4 Hospice cost-sharing is not subject to the catastrophic cap provisions since it is optional and already offset in the established national rates.

3.2.5 The amount of the individual cost-share liability for respite care during a hospice cost-share period may not exceed the Medicare inpatient hospital deductible applicable for the year in which the hospice cost-share period began. The individual hospice cost-share period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

Example: Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice cost-share period. Therefore, the maximum cost-share for respite care during the three periods of hospice care may not exceed the amount of the inpatient deductible for the year in which the first period began.

3.2.6 The TRICARE payment rates are not reduced when the individual is liable for coinsurance payments. Instead, when establishing the payment rates, TRICARE offsets the estimated cost of services by an estimate of average coinsurance amounts hospices collect.

Note: Since the services and supplies associated with the palliative treatment of beneficiaries electing hospice care under TRICARE are included in the all-inclusive rates and the rates are already reduced/offset by the estimated average cost-sharing, the contractors will not be responsible for monitoring whether or not the hospice has waived cost-sharing for a particular service. The cost-sharing calculation will not be a part of the reimbursement methodology for payment of hospice claims.

3.2.7 Since TRICARE payment rates are not to be reduced when beneficiary liability is reported by the hospice (i.e., when the provider indicates that a cost-share was collected from the beneficiary), the following guidelines should be applied when beneficiary cost-sharing is reported on the hospice claim form:

- List a cost-share amount of $0.00 on TRICARE Explanation of Benefits (TEOB) for all services;
- Do not retain a history of any cost-share payments reported on the claim form by the hospice; and
- Do not apply any amount of the reported cost-share to the catastrophic cap.

3.3 Medical Review of Hospice Claims

The contractor will request and review medical records (post-payment medical review), including written plans of care, to make sure that appropriate payments are made for services provided to individuals electing hospice care.

3.3.1 Criteria for Review

The post-payment medical review process must ensure that services provided were:

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

3.3.2 Time Frame for Receipt of Medical Records

The hospice program must submit all medical records and/or documentation within 30 days of the date the contractor requested them. Failure to receive the requested information within the designated time frame (30 days from date of request) will result in the denial of all related claims. The hospice will be liable for the costs of the noncovered services. The hospice may not attempt to collect any amounts for services for which the beneficiary was entitled to have TRICARE payment made had the hospice complied with certain procedural requirements (e.g., requested information for post-payment medical review, refer to Addendum D, Article 3.4 of the Participation Agreement for Hospice Program Services for TRICARE Beneficiaries).

Note: Medical review will be the responsibility of those contractors processing the claims. The contractor will only be looking for utilization trends on random samples. A pattern of failure to adequately meet the medical review criteria specified in paragraph 3.3, will result in denial or reclassification of the particular rate category. The notice of denial or reclassification of the hospice care will be retrospective (post payment) and result in a claim adjustment (recoupment action). A duplicate claim adjustment (EOB) would be sent to both the provider and the beneficiary. The beneficiary will be held harmless for those services for which the provider would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements (refer to Addendum D, Article 3.4, of the Participation Agreement for Hospice Program Services TRICARE Beneficiaries). The contractor will be given discretion in determining at what point care will be denied for lack of supporting medical documentation.

3.3.3 Reclassification of Level of Care

The contractor may reclassify care from one rate category to another as a result of their review. The contractor will be responsible for adjusting the reimbursement on the previously processed claims to the appropriate level of care.

Example: If continuous home care was provided to a patient whose condition did not require the level of care described in paragraph 3.1.1.2, payment will be made at the appropriate level (in this case, the routine home care rate.)

3.3.4 Related Services

All services and/or 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).

3.3.4.1 The hospice will be responsible for providing medical appliances (which includes covered durable medical equipment (DME) (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.

3.3.4.2 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, representatives from Medicare have informed us that these types of therapies would be relatively rare in a hospice setting since they are considered life sustaining treatment modalities.

3.3.4.3 Ambulance services would be covered under the daily hospice rate if determined necessary for management of the patient's terminal illness (e.g., ambulance transport from the patient's residence to a hospice inpatient facility).

- END -