

## COMMUNITY HOSPICE CARE: REFERRAL AND PURCHASE PROCEDURES

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook describes the procedures for the referral and purchase of hospice services from community providers, including hospice care provided at home or in an institution as an inpatient.
- 2. SUMMARY OF CONTENTS:** This is a new VHA Handbook that describes the procedures for meeting the hospice needs of enrolled veterans through the working relationships between Department of Veterans Affairs (VA) facilities and community hospice agencies.
- 3. RELATED ISSUES:** VHA Handbook 1140.3.
- 4. RESPONSIBLE OFFICE:** The Office of Geriatrics and Extended Care (114) is responsible for the contents of this Handbook. Questions may be referred to 202-273-8543.
- 5. RECISSIONS:** None.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of March 2010.

S/Jonathan B. Perlin, MD, PhD, MSHA, FACP  
Acting Under Secretary for Health

DISTRIBUTION: CO: E-mailed 3/3/2005  
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 3/3/2005

**CONTENTS**

**COMMUNITY HOSPICE CARE: REFERRAL AND PURCHASE PROCEDURES**

<b>PARAGRAPH</b>	<b>PAGE</b>
1. Purpose .....	1
2. Background .....	1
3. Definitions .....	1
4. Scope .....	2
5. Eligibility for Hospice and Palliative Care .....	2
6. Authority.....	3
7. Procedures for VA Referral to Community Hospice Care .....	3
8. VA Guidelines for Purchasing Hospice Care .....	5
9. Procedures for Referral of Veterans to VA for Hospice Care .....	7
10. References .....	7
<b>APPENDIX</b>	
A Estimating Prognosis in Non-cancer Diseases .....	A-1

## COMMUNITY HOSPICE CARE: REFERRAL AND PURCHASE PROCEDURES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook describes the procedures for the referral and purchase of hospice services from community providers, including hospice care provided at home or in an institution as an inpatient. It describes the options and procedures for meeting the hospice needs of enrolled veterans through the working relationships between Department of Veterans Affairs (VA) facilities and community hospice agencies. This Handbook specifies:

- a. The process for referring a veteran to a community agency for hospice care;
- b. The coverage and payment structure for purchased hospice care;
- c. VA's options for providing or purchasing inpatient hospice care.

### 2. BACKGROUND

- a. All VA facilities have a Palliative Care Consult Team (PCCT) as a resource for hospice and palliative care provided in the VA facility and coordinated in the community.
- b. VA utilizes community hospice agencies to provide the majority of home hospice care for veterans choosing to receive hospice care.
- c. VA in general does not operate a home hospice service, and does not duplicate the services available through referral or through the purchase of home hospice care from community agencies.
- d. In the past, VHA furnished home hospice services through a limited fee for service program. Today, all enrolled veterans are eligible for a comprehensive array of needed in-home services. These services in VA's Medical Benefits Package, including hospice and palliative care, are playing an increasingly important role in VHA's integrated health care delivery system (see Title 38 Code of Federal Regulations (CFR) 17.38(a)(1)(xi)A).

### 3. DEFINITIONS

- a. **VHA Hospice and Palliative Care.** VHA Hospice and Palliative Care is care in which the primary goal of treatment is comfort rather than cure in a person with an advanced disease that is life-limiting and refractory to disease-modifying treatment; this includes bereavement care to the veteran's family.
- b. **VHA Hospice Care.** VHA Hospice Care is care provided to a veteran meeting all of the following criteria; the veteran:

(1) Is diagnosed with a life-limiting illness.

(2) Has treatment goals focused on comfort rather than cure.

(3) Has a life expectancy, deemed by a VA physician, to be 6 months or less if the disease runs its normal course. *NOTE: This is consistent with the prognosis component of the Medicare hospice criteria.*

(4) Accepts hospice care.

c. **Life-limiting Illness.** A life-limiting illness is a disease or condition that is expected to significantly shorten life span.

d. **Certified Hospice Agency.** A Certified Hospice Agency is licensed or otherwise state-approved or is certified by Medicare or Medicaid as a hospice agency. Accreditation by other organizations is neither necessary nor sufficient for a home care or hospice agency to be certified for VA care.

e. **Bundled Per Diem Hospice Services.** Bundled per diem hospice services are the comprehensive package of services covered and provided by a Certified Hospice Agency, to include: hospice diagnosis-related home visits by professional and paraprofessional staff, homemaker and home health aide services, medications, supplies, biologicals, durable medical equipment, and ancillary services as outlined in the plan of care. Services are provided as needed and purchased on a per diem basis for a period of consecutive days of covered service, independent of frequency of visits or intensity of services provided during the covered period.

#### 4. SCOPE

a. Hospice and palliative care collectively represents a continuum of comfort-oriented and supportive services provided in the home, community or inpatient settings for veterans with advanced, life limiting disease. Support is provided for the veteran's family or caregivers, including bereavement support following the death of the veteran.

b. VA ensures that all enrolled veterans in need of hospice and palliative care are able to obtain these needed services.

#### 5. ELIGIBILITY

a. Hospice and palliative care is a covered benefit for all enrolled veterans, on par with all other medical services included in the Medical Benefits Package. VA offers to provide or purchase needed hospice and palliative care services for all enrolled veterans, whether these services are needed in an inpatient setting or in the home.

b. A veteran who is dually eligible for both VA care and Medicare may elect to have hospice services paid for under the Medicare Hospice Benefit. Veterans who choose Medicare retain their eligibility for VA care and benefits. *NOTE: Veterans need to be notified that VA has no*

*authority to pay for any balances or co-payments that may be due after Medicare or any other non-VA source makes payment for hospice care.*

## **6. AUTHORITY**

a. Hospice and palliative care are authorized under 38 CFR 17.38(a)(1)(xi)(A).

b. The Fee Basis statute, Title 38 United States Code (U.S.C.) 1703, is not to be used for the purchase of hospice care. The fee package accounting system continues to be used to process placements and obligations.

## **7. PROCEDURES FOR VA REFERRAL TO COMMUNITY HOSPICE CARE**

a. A veteran or, with the veteran's authorization or approval, a surrogate or referring health care professional, may request that VA assess the veteran's need for hospice services.

b. The veteran is evaluated by VA health care professional(s) regarding hospice care, including patient and family values, goals of care, and the resources available to the veteran.

c. If a community hospice referral is determined to be appropriate, the VA Community Health Nurse Coordinator, social worker, or other VA health care professional identifies and discusses with the veteran the options for care setting, certified agencies, and payer.

d. The veteran is offered the choice among certified agencies and payers. *NOTE: If there are no certified agencies that provide coverage to the area in which the veteran lives, then hospice care may be purchased from the agency deemed by VA to be the best option.*

e. If the veteran elects to receive hospice care through Medicare or another non-VA source, VA coordinates with the community hospice to ensure that the needed amount, duration and scope of services are delivered to the patient and family. The community hospice maintains clinical, financial and administrative responsibilities for all covered services and ensures that hospice staff meets regulatory qualification requirements. VA may purchase additional needed home care services that are beyond the scope of non-VA coverage. In such instances, VA is to obtain documentation from the agency defining the agency's limitations and stating that the needed services are beyond their scope of coverage for all patients under their care.

f. Upon referral for home hospice care, the following information must be provided to the community hospice agency. Release of information is performed in accordance with disclosure policies outlined in VHA Handbook 1605.1

(1) Name and contact number of the VA person making the referral.

(2) Patient and family demographic information and payment source.

(3) Name and telephone numbers of the surrogate decision maker, if applicable.

(4) Admitting diagnosis and prognosis, current medical findings including clinical indicators, history of changes in indicators and data to support the terminal diagnosis, dietary information or requirements, orders for medication, treatment and symptom management, and information about the medical management of patient conditions that are unrelated to the terminal illness.

(5) Name, telephone number, and fax number of the physician who will follow the patient and designation of an alternate physician to contact in the event that physician is not available during a patient emergency or non-business hours.

(6) Any information and documentation about discussions relating to advance directives, the resuscitation status of the patient, and patient's, surrogate's, and/or family's preferences regarding end of life care.

(7) Identification of any other agencies involved in the care.

g. A VA physician is to: make the determination of need for hospice; deem whether life expectancy is less than 6 months, if the disease takes its normal course; and make the referral contact or sign the referral form to the hospice agency. **NOTE:** *Recognizing that prognosis cannot be predicted with certainty, physicians are advised to use the National Hospice and Palliative Care Organization's Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, Second Edition, (see App. A). While these prognostic guidelines are useful in determining eligibility for the Medicare Hospice Benefit, they are to be used as a guide, not a rigid requirement. Some patients appropriate for hospice survive longer than 6 months. Periodic reevaluation of patients, their prognoses, and their expected benefit from hospice care needs to be documented in the care plan.*

(1) Every patient receiving care by a community hospice agency is required to have both a primary care physician as attending of record, and a hospice medical director.

(2) VA encourages the referring VA staff physician to remain as the primary care physician attending of record during community hospice care. The VA staff physician serving as attending of record for hospice care must, within the limits of ability and authority, sign relevant hospice care orders and forms, and participate with the care plan team. The care plan is controlled by the agency team, not by the physician. **NOTE:** *Since the care plan is controlled and implemented by the agency team and not by the VA physician, the hospice care is not subject to a Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) survey as part of the VA facility JCAHO accreditation process.*

(3) VA encourages an agreement whereby the hospice agency controls the care plan, communicates with the VA primary care physician regarding status and changes, and contacts the VA primary care physician when a change in care plan occurs or when physician involvement is required. **NOTE:** *In those instances in which the VA primary care physician cannot be reached or is unable to provide the needed physician service, the hospice medical director serves as back-up physician.*

(4) When physician action is required that is beyond the oversight responsibility of the hospice medical director or attending of record, such as making a home visit, VA has the option to directly provide that physician service or to request the necessary physician services through the covering hospice agency.

## 8. VA GUIDELINES FOR PURCHASING HOSPICE CARE

a. VA offers to provide or purchase hospice care that VA determines an enrolled veteran needs. If a veteran is enrolled in the VA health care system and chooses VA to be the payer, then VA is responsible for purchasing or providing the needed hospice services. Veteran choice of payer applies even if the veteran is eligible for hospice under Medicare or Medicaid.

b. VA purchase of community hospice care must be comprehensive, bundled per diem services for a specified period of service. Hospice care may be recertified for additional specified periods of service if needed. VA-purchased community hospice care covers hospice diagnosis-related home visits by professional and paraprofessional staff, medications, supplies, biologicals, durable medical equipment and ancillary services as outlined in the plan of care. Community hospice care also covers bereavement for the family as part of the hospice care plan, without additional reimbursement.

c. Hospice care rates are reflective of a per day reimbursement, not per visit. The rate is paid for a designated period of consecutive days, without regard to the volume or intensity of services provided on a given day, as described in VHA Handbook 1140.3. To cover physician hospice services that are beyond the scope of routine hospice care, VA may add up to \$1.00 per day to the local negotiated rate.

d. Purchased home hospice care must be coded using Purpose of Visit (POV) code 77. The secondary International Classification of Diseases - 9<sup>th</sup> Edition (ICD-9) code v66.7 for palliative care is to accompany a primary diagnosis ICD-9 code for the encounter.

e. The Hospice Benefit under Medicare, Medicaid, and most private insurances, cover four levels of care, two of which are delivered in the patient's place of residence and two in an inpatient setting. The four levels of care are:

- (1) Routine Home Care (delivered in the patient's place of residence);
- (2) Continuous Care (more than 8 hours per day of predominantly nursing care delivered in the patient's place of residence);
- (3) Inpatient Respite Care (care given to hospice patient in order that the usual caregiver can rest); and
- (4) General Inpatient Care (care requiring and delivered in an inpatient setting).

f. The agreement between the hospice and the VA facility must address all four of these levels of care prior to the patient's admission to the community hospice, consistent with Medicare practices (see VHA Handbook 1140.3). Specific issues to be addressed include:

(1) The location and reimbursement rate for home hospice care. Home hospice care is provided in the patient's residence, which may be a home, a nursing home or other community-based residential setting. The Continuous Care level of hospice care is indicated when a patient requires between 8 and 24 hours a day of predominantly nursing care to achieve palliation or to manage acute medical symptoms and maintain the patient at home.

(2) The location and reimbursement for inpatient care, both related and unrelated to the terminal diagnosis. The agreement must include stipulations for contacting VA for authorization prior to admission for inpatient care. When hospital care is needed VA will generally offer to provide the care in a VA hospital. VA will pay for a veteran's care in a non-VA hospital only in exceptional circumstances and with prior VA authorization. When the inpatient care can be provided in a nursing home, VA uses three options as described in subsequent sections. Inpatient care is indicated when:

(a) Pain and other symptoms cannot be managed in the home setting (General Inpatient level of care).

(b) Patient requires hospitalization for reasons unrelated to the terminal diagnosis (General Inpatient level of care).

(c) Patient's family or caregiver needs an extended break from caring for the veteran (Respite level of care).

(3) When a veteran receiving VA-paid home hospice care is admitted to a VA facility for inpatient care anticipated to be of short duration, VA may continue the coverage by the hospice agency and will reimburse the agency for up to five days at the home hospice rate. VA expects the hospice agency to maintain phone contact with the patient, family and VA providers during an inpatient stay, to facilitate the transitions at admission and discharge, and to be prepared for immediate resumption of care upon discharge to home.

g. When inpatient hospice services become necessary, VA has three options (see VHA Handbook 1140.3):

(1) Generally, VA provides needed inpatient hospice care at a VA facility. This is the preferred option for many veterans.

(2) VA may utilize Community Nursing Home (CNH) contracts to purchase inpatient hospice services. Only CNHs with established hospice agency relationships can be used.

(a) To ensure the proper continuation of the hospice care plan upon admission to the CNH:

1. VA pays the hospice agency a \$60.00 per diem rate for hospice consultation services; or



2. VA pays the full routine home care hospice rate while the patient remains in CNH, if the hospice agency provides consultative services as well as hospice diagnosis-related medications, biologicals, and durable medical equipment. *NOTE: If this option is taken, the consultation fee will not be paid.*

(b) When a veteran is placed by VA in a CNH for the purpose of hospice care, the cost of care including the nursing home portion of that care is covered by the VA hospice benefit.

(3) VA may purchase inpatient hospice services from a community provider, at local negotiated rates.

h. If a VA CNH patient's care plan is amended by the CNH or VA physician to include hospice care services, the veteran may request hospice care through VA, or may obtain needed hospice services through Medicare, Medicaid, or private insurance if eligible. If VA is requested to provide hospice care, VA can purchase the care either as hospice consultation or as full-service hospice care, as described in the preceding paragraphs.

i. If a veteran is receiving inpatient care at a non-VA facility, not at VA expense, and requests inpatient hospice care from VA, policies on VA inpatient care and transfer will apply.

## **9. PROCEDURES FOR COMMUNITY REFERRAL TO VA FOR HOSPICE CARE**

a. Community hospices are advised to make a practice of asking all potential patients if they are veterans. If a veteran is already enrolled in and receiving care through the VA, the community hospice agency is encouraged to call the veteran's preferred VA medical center and ask for the Community Health Nurse Coordinator, social worker, or Palliative Care Consult Team Coordinator. *NOTE: To find the local VA medical center, visit [www.va.gov](http://www.va.gov). Click on "Health Benefits and Services," and then select "Locate a VA Medical Center."*

b. If a veteran is not enrolled in or receiving care through the VA and wishes to enroll for VA health care, then the hospice agency is advised to contact the closest VA medical center in order to initiate the enrollment process. Ask to speak with a social worker or the Community Health Nurse Coordinator.

c. If a veteran enrolled in Medicare hospice is admitted to a VA facility for VA inpatient care that is anticipated to be of short duration, VA allows the veteran to remain enrolled in Medicare home hospice. While the VA provides all necessary inpatient care during the veteran's admission in a VA facility, VA expects the hospice agency to:

- (1) Maintain contact with VA staff, the veteran, and/or family during the hospital stay;
- (2) Participate in discharge planning; and
- (3) Be prepared to resume all covered services promptly upon discharge.

d. Billing and other administrative details must be covered in the basic ordering agreement or statement of work.

**10. REFERENCES**

a. Title 38 CFR 17.38(a)(1)(ix), and 7.38(a)(1)(xi)A, VA Medical Benefits Package.

b. VHA Handbook 1140.3.

c. Related hospice and palliative care documents can be found through the VA Geriatrics and Extended Care website: [www.va.gov/geriatricsshg](http://www.va.gov/geriatricsshg) .

**ESTIMATING PROGNOSIS IN NON-CANCER DISEASES**

*NOTE: The following guidelines are adapted from Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, 2<sup>nd</sup> Ed., National Hospice Organization, Arlington, VA, 1996.*

Fulfilling the criteria for any of the categories supports that a patient has a prognosis less than 6 months to live, and may be deemed appropriate for hospice care and referral for the Medicare hospice benefit. *NOTE: Other criteria may apply.*

**1. General.** The patient meets all the following:

a. Life-limiting condition;

b. Treatment goals are for comfort rather than cure;

c. In the past 6 months, the patient has either documented terminal disease-related decline in nutritional status (a weight loss of more than (>) 10 percent) or clinical progression of disease (repeated emergency room or inpatient admissions, or functional status decline).

**2. Congestive Heart Failure.** The patient meets, on optimal treatment:

a. Class IV heart failure or ejection fraction of less than (<) 20 percent; and

b. Syncope, cardiac arrest, cardiogenic stroke, or symptomatic arrhythmia.

**3. Chronic Obstructive Pulmonary Disease.** The patient meets some of the following:

a. Dyspnea at rest unresponsive to bronchodilators. Forced Expiratory Volume (FEV1) after bronchodilator < 30 percent of predicted.

b. Dyspnea limits walking to a few steps; resting tachycardia > 100.

c. Resting partial pressure of carbon dioxide (pCO<sub>2</sub>) > 50; oxygen saturation < 88 percent or partial pressure of oxygen (pO<sub>2</sub>) < 55 on supplemental oxygen; Cor pulmonale.

d. Weight loss > 10 percent of body weight.

**4. Renal Failure.** Chronic renal failure with creatinine > 8.0 milligram per deciliter (mg/dL), off dialysis.

**5. Cirrhosis and/or Liver Failure.** With clinical judgment, the patient:

a. Spends most time in bed, International Normalized Ratio (INR) > 1.5, albumin < 2.5 gram per deciliter (g/dL).

b. Evidences comorbidity: encephalopathy, spontaneous bacterial peritonitis, refractory ascites, recurrent variceal bleeding, hepatorenal syndrome, or wasting.

**6. Dementia.** The patient meets all the following:

- a. Speech limited to six words;
- b. Bed-bound;
- c. Incontinent;
- d. Unable to ambulate, dress, and bathe without assistance; and
- e. A comorbidity in prior year; i.e., pyelonephritis, pressure ulcer, sepsis, fever after antibiotics, difficulty feeding with aspiration pneumonia, or a weight loss > 10 percent.

**7. Human Immunodeficiency Virus (HIV) Disease.** The patient meets some of the following:

- a. CD4+ count below 25 cells per microliter ( $\mu\text{L}$ );
- b. Viral load > 100,000 per milliliter (ml);
- c. Declining functional status;
- d. Certain opportunistic infections;
- e. Albumin < 2.5 g/dL.

**8. Strokes and/or Coma**

- a. **Acute Phase.** The patient meets any of the following:
  - (1) Coma or persistent vegetative state 3 days after stroke.
  - (2) Any four of the following on day three of a coma:
    - (a) No verbal response.
    - (b) Abnormal brain stem response.
    - (c) No response to pain.
    - (d) Serum creatinine > 1.5 mg/dL, Age > 70.

(e) Dysphagia preventing adequate intake in a patient who is not a candidate for artificial nutrition.

b. **Chronic Phase.** The patient meets some of the following:

(1) Poor functional status;

(2) Dementia dependent in ambulation, dressing, bathing and toileting;

(3) Weight loss > 10 percent, albumin < 2.5g/dL.

(4) Complications to include: aspiration pneumonia, pyelonephritis, sepsis, stage three or four decubitus, and/or fever after antibiotic.

**9. Amyotrophic Lateral Sclerosis (ALS).** The patient evidences a rapid progression of ALS, with decline in one of the following:

a. Ventilatory capacity,

b. Swallowing, or

c. Functional status.