

CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 16.4
TITLE: HOSPICE

AUTHORITY: 38 CFR 17.270(a)

RELATED AUTHORITY: 32 CFR 199.6(b)(4)(iii); 32 CFR 199.14(g)

I. EFFECTIVE DATE

February 6, 1995

II. PROCEDURE CODE(S)

HCPCS S9126

III. DESCRIPTION

The hospice benefit is designed to provide palliative care to individuals with prognoses of less than 6 months to live if the terminal illness runs its normal course. The benefit is based upon a beneficiary and family-centered model. Views of the beneficiary and family and/or friends figure predominately in the care decisions. Since this type of care emphasizes supportive services, such as pain control, symptom management, and home care, rather than cure-oriented treatment, the hospice benefit is exempt from those limitations on custodial care and personal comfort items currently in force under the CHAMPVA program. Hospice services are provided to the beneficiary and family by a team of highly skilled professionals and trained volunteers. The hospice team works together to help beneficiaries live each day as fully and comfortably as possible.

IV. POLICY

A. Hospice benefits must be preauthorized.

B. The hospice benefit must be elected by the beneficiary or the beneficiary's legal representative; i.e., an attorney, medical proxy or medical power of attorney, or guardian.

1. Hospice election can be revoked at any time and re-elected at a later date. However, to change providers or benefit periods, preauthorization is required.

2. On occasion, a terminally ill beneficiary's health improves or the beneficiary's illness goes into remission while receiving hospice care. A beneficiary's condition may become stable to the point that the hospice team and physician(s) believe the beneficiary is no longer terminally ill (less than six months to live). If that determination is made, CHAMPVA will discontinue hospice coverage. If skilled nursing services are required, coverage is provided under the CHAMPVA program for skilled nursing care.

3. At any point, a beneficiary can return to hospice care, as long as the eligibility criteria is met and certification by the physician(s) and hospice team is received.

4. A beneficiary who elects to receive care under a hospice program cannot receive curative treatment related to the terminal illness unless the hospice care has been formally revoked.

NOTE: A hospice beneficiary always has the right to stop receiving hospice care. If the beneficiary chooses to stop hospice care, health care benefits from CHAMPVA will continue.

C. The provider must be Medicare certified.

D. For coverage, the following documentation is required:

1. Attending physician's statement that the beneficiary has a terminal illness with a life expectancy of six months or less (if the disease runs its normal course).

2. An election (contract) of hospice signed by the beneficiary or legal representative.

3. A treatment plan must be established before services are provided.

E. Hospice beneficiaries will still receive basic CHAMPVA benefits for treatment of conditions that are unrelated to their terminal illness. **Treatment unrelated to the terminal illness is cost shared along with any applicable deductibles.**

NOTE: If the beneficiary has cancer and falls and breaks his/her hip, CHAMPVA will cover the hip treatment as inpatient or outpatient care, independent of hospice care. However, if the beneficiary's condition has worsened and home skilled nursing services are required for the hip treatment, in addition to the hospice care, only one of these services can be paid. In this case, the hospice is contacted and the service that takes priority will be the covered/paid service provided.

F. Services provided under hospice may be at one of four levels:

1. Routine home care. Intermittent care provided in the beneficiary's home, nursing home, or assisted living center.

2. Continuous home care. Care is furnished only during periods of crisis and when necessary to maintain the beneficiary at home. A period of crisis is defined as the time a beneficiary requires continuous care to achieve palliation or management of acute medical symptoms. Continuous home care is at least eight hours long and consists predominately of continuous nursing care, although home health aide and homemaker services may also be provided on a continuous basis.

3. Inpatient respite care. Care in an approved Medicare facility such as a freestanding hospice facility, a hospital, a nursing home, or other long-term care facility on a short-term basis (not more than five days at a time) to relieve the family members or other persons caring for the individual at home.

a. Respite care can only be provided on an occasional basis and then only if it is part of the overall treatment plan.

b. The hospice team has the responsibility of determining the appropriateness and frequency of respite care.

4. General inpatient care. Care in approved facilities for pain control or acute or chronic symptom management that cannot be achieved in other settings. This level of care may be provided in a hospital, a hospice with its own inpatient facility, or a skilled nursing facility.

G. Beneficiaries can continue to receive hospice care for as long as the physicians continue to recertify the terminal illness. However, if the beneficiary is stable or the hospice care extends beyond six months, the hospice benefit is subject to medical review.

V. POLICY CONSIDERATIONS

A. The hospice team must develop a care plan that focuses on the beneficiary's well-being and the need for pain management and symptom control. The plan must outline the medical and support services required. The medical support team usually consists of:

1. the beneficiary's family/caregiver,
2. the beneficiary's personal physician,
3. hospice physician (or medical director),
4. nurses,

5. home health aides,
6. social workers,
7. clergy or other counselors,
8. trained volunteers, and
9. speech, physical, and occupational therapists, if needed.

B. The support services, as long as they relate to the terminal diagnosis, usually include the following and are part of the all-inclusive (per diem) hospice rate (see Chapter 3, Section 13.1, *Hospice Reimbursement*).

1. Physician services for the medical direction of the beneficiary's care, provided by either the patient's personal physician or a physician affiliated with the hospice program.

2. Regular home care visits by or under the supervision of a registered professional nurse. The actual hands-on care may be provided by licensed practical nurses to monitor the beneficiary's condition and provide appropriate care to maintain the beneficiary's comfort.

3. Home health aide and homemaker services when provided by individuals who have successfully completed a home health aid training and competency evaluation program. Certification and training is offered through the hospice provider. Services must be provided under the general supervision of a registered nurse. These services consist of personal care services and household services to maintain a safe and sanitary environment; for example, changing of beds and light housekeeping.

4. Chaplain services for the beneficiary and/or loved ones, if desired.

5. Social services, including counseling, are provided for the purpose of assisting the beneficiary and his/her family in adjusting to the beneficiary's approaching death.

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

7. Medical equipment to include durable medical equipment (i.e., hospital beds, oxygen, and wheelchairs) as well as other self-help and personal comfort items related to the palliation or management of the beneficiary's terminal illness.

8. Medical supplies to include those items that are part of the written plan

of care (i.e., bandages and catheters).

9. Drugs for the relief of pain and symptom control related to the beneficiary's terminal illness.

10. Volunteer support to assist the beneficiary and loved ones.

11. Speech, physical, occupational, and massage therapy may be provided for purposes of symptom control or to enable the beneficiary to maintain activities of daily living and basic functional skills.

C. Parental and enteral nutrition therapies are covered under the daily hospice rate if determined to be essential for the palliative care of the terminal beneficiary. These therapies would be rare in a hospice setting since they are considered life sustaining treatment modalities.

D. Services not covered in the all-inclusive (per diem) hospice rate are:

1. services rendered by an independent attending physician,
2. services for conditions unrelated to the terminal illness, and
3. services for the terminal diagnosis that are not included for in the hospice care plan or arranged for by the hospice program.

E. Documentation may be requested for medical review for conditions that are determined by the hospice to be unrelated to the terminal illness.

VI. EXCEPTIONS

If the beneficiary receives hospice care provided by a VAMC under the CITI (CHAMPVA Inhouse Treatment Initiative) program, the CITI facility does not have to be Medicare-certified/approved.

VII. EXCLUSIONS

A. Services from another provider that duplicates the care received through the hospice.

B. Services provided by a hospice program that are not Medicare-certified/approved.

C. Room and board for residential hospice care in lieu of living at home (i.e., nursing home, boarding home, hotel or relative's home).

END OF POLICY