APPENDICES

A. Sample Hospice Policy - General Inpatient Level of Care

B. Assessment Checklist for the General Inpatient Level of Care

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D. Sample Hospice/Hospital Contract for General Inpatient Level of Care

E. "Hospice Contracting for the Provision of General Inpatient Level of Care."
   Mary H. Michael, JD and Matthew K. McManus, JD, Reinhardt Boerner Van Deuren,
   Madison, Wisconsin

F. “A Legal View. Corporate Compliance and Provision of General Inpatient Level Care:
   Selected Risk Areas.” Mary H. Michal, JD. Reinhardt Boerner Van Deuren,

G. Physician and Nurse Practitioner Billing in the General Inpatient Level of Care

H. Sample Hospice Benefit Facility Reimbursement Form

I. References for Other Regulatory Requirements for General Inpatient Units
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J. Medicare Hospice Condition of Participation: Short-term inpatient care (NEW June 5, 2008)
Appendix A

GENERAL INPATIENT LEVEL OF CARE
Sample Policy

PURPOSE:
To establish the criteria and service provisions for a patient admitted to the General Inpatient Level of Care (GIP)

POLICY:
Inpatient care or services means short-term, general inpatient care provided either through a contract arrangement with an appropriately licensed and certified hospital or long term care facility or directly by a hospice program in its hospice inpatient facility to provide pain control or symptom management that cannot be accomplished in the home or community.

The patient, family/caregiver, physician and hospice interdisciplinary team participate in the evaluation of the appropriate level of care and the decision regarding the provision of care in an inpatient facility. The Hospice will be responsible for the coordination of services rendered to patients during inpatient stays.

Inpatient care will be provided as specified under the Medicare/Medicaid hospice benefit and commercial private insurance hospice benefits.

CRITERIA FOR ADMISSION TO THE GENERAL INPATIENT LEVEL OF CARE:
A patient appropriate for the GIP benefit may present with one or more of, but not limited to, the following:

Pain requiring:
- Complicated technical delivery of medication requiring skilled nursing care for calibration, tubing change, or site care
- Frequent evaluation by physician/nurse
- Aggressive treatment to control pain
- Frequent medication adjustment
Symptom changes:
- Sudden deterioration requiring intensive nursing intervention
- Uncontrolled nausea and vomiting
- Pathological fractures
- Respiratory distress which becomes unmanageable
- Transfusions for relief of symptoms
- Traction and frequent repositioning requiring more than one staff member
- Wound care requiring complex and/or frequent dressing changes that can not be managed in the patient’s residence
- Severe agitated delirium or acute anxiety or depression secondary to the end-stage disease process requiring intensive intervention and not manageable in the home setting

Imminent Death
(As evidenced by mottling, respiratory status, and level of consciousness).
- Symptom management requiring frequent skilled nursing intervention. Imminent death alone is not the criterion for the GIP level of care.

CRITERIA FOR CONTINUED STAY IN THE INPATIENT LEVEL OF CARE:
- Hospice is continuing to work with family to provide conditions for safe discharge.
- Pain continues to require active treatment and frequent assessment
- Symptoms such as intractable nausea/vomiting, respiratory distress, open lesions or ongoing deterioration related to the terminal illness continue to require active treatment and frequent assessment
- Ongoing mental status changes which requires active treatment and frequent assessment
- Death is imminent evidenced by clinical deterioration such as mottling of the skin, change in respiratory status, and level of consciousness. The family is unable to cope or the patient requires frequent skilled nursing intervention

CRITERIA FOR DISCHARGE FROM THE INPATIENT LEVEL OF CARE:
- Reason for admission has stabilized
- Family support system is re-established
- Appropriate discharge plan has been developed
- Transfer to another level of care

PROCEDURE:
1. Prior to admission, the Hospice will determine whether the patient is appropriate for GIP level of care based on established criteria. In assessing the patient, consider the following:
   A. If continuous care were used, could the patient’s condition be managed at home?
   B. Could the problem be managed in the home with more resources?
   C. What is the goal of admission to a skilled nursing facility or hospital? Does the
patient/family understand that inpatient care is for a short duration and only until the patient's condition can be stabilized?

D. Does the hospice have a contract for inpatient level of care with the facility? If the patient is in the hospital for an acute situation and is not currently a SNF patient, the Liaison Nurse will screen for appropriateness for inpatient level of care and obtain signatures on the Inpatient Level of Care Acknowledgment form from the patient or family/caregiver if appropriate. (See Appendix D for sample)

2. The Hospice staff member contacts the appropriate team member (which may include the clinical supervisor, team leader or Hospice Medical Director), the attending physician, and, if applicable, the insurance case manager.

3. The Hospice staff member contacts the inpatient facility's Admission Department or facility designee if off-hours, to arrange for the direct admission (bypassing the Emergency Department if hospital setting) of the hospice patient, identifying the insurance source. The hospice must have a contract with the facility to provide the GIP level of care.

4. The Hospice staff member arranges for transportation to the facility with a contracted ambulance service, if needed. The appropriate Hospice staff member will provide the Nursing Unit of the inpatient facility with a written transfer/referral form summary that includes medications, the hospice plan of care, advance directives and a narrative summary indicating current clinical and psychosocial issues.

The Hospice staff member:
- Requests a waiver of routine admission tests from the attending physician
- Notifies the IDT of the change in service level.

5. The Billing Manager sends confirmation of financial arrangement to the facility (See Appendix E)

6. The Hospice staff member makes a first visit within 24 hours of admission and:
- Confers with facility staff regarding the Plan of Care (PoC) and goals for the GIP stay
- Flags the facility record as to the patient's hospice status
- Assures completion of the transfer/referral form and places the original in the inpatient clinical record with a copy to the Hospice record.
- Leaves a copy of the Hospice Plan of Care in the inpatient clinical record, including the discharge plan.

7. The Hospice staff member develops a collaborative Plan of Care with the facility
- A PoC for GIP should include at a minimum, daily contact by a core member of the IDT with the patient (primarily visits), supplemented with volunteer visits as indicated.
8. Responsibilities of the team include:
- Revise the Plan of Care to reflect the patient status upon admission and throughout the course of the GIP stay as needed but at a minimum, every fourteen days
- All staff will represent Hospice and advocate for the patient
- All staff visiting the patient will wear ID badges

- A Hospice may choose to develop protocols for the routine responsibilities of each IDT member (optional)

9. Documentation should include qualifying and quantifying information justifying admission to GIP and continued stay.

10. The Hospice confers with the facility’s staff regarding discharge planning but the Hospice retains responsibility for the patient’s discharge plan.

The Hospice & Palliative Care Federation thanks the following hospices for contributing their policies that supported the development of this sample.

Community Health and Counseling Services Hospice, Bangor, ME
Hallmark Health Hospice, Malden, MA
Hospice of the North Shore, Danvers, MA
VNA Hospice Care, Woburn, MA

rev 3/08
Appendix B

The purpose of this tool is to help those providing GIP care in any setting. It is not intended to provide definite criteria or formats and but rather to act as a guide with examples to help the interdisciplinary team process in assessment, goal identification and the establishment and communication of the Plan of Care.

Assessment Tool
for the General Inpatient Level of Care

Purpose
To assist the hospice interdisciplinary team in determining and documenting patient eligibility for the general inpatient level of care.

Assessing the need for change to GIP level
The IDT should discuss and document the change in patient’s condition or circumstances that requires a change in the individual’s Plan of Care.

- Does the pain remain in need of pain control or symptom management?
- What was the precipitating event that has led to the need for a change to GIP status?
- Why is care at home no longer feasible?
- If the patient is in a hospital setting, why is a SNF or residential hospice setting not appropriate?

Determining eligibility
Does the patient meet any of the following:

- Acute symptom management needs can not be met at home as a result of the collapse of family caregiving support.

- A transfer from the home setting is required for the treatment of pain or symptoms that can not be managed in a home setting. Examples include:
  - Interventions provided at home have not effectively managed the symptom
  - Complicated technical interventions are needed
  - Frequent evaluation and medication adjustments by a nurse or MD are necessary
  - Uncontrolled nausea or vomiting
  - Pathological fractures which require more than one person for repositioning and care
  - Uncontrolled dyspnea
  - Open lesions needing frequent skilled care or complicated dressings
  - Patient/family teaching for complex medications or treatments is needed
  - Acute symptoms of imminent death require skilled nursing care
  - A likelihood that the patient may die within 24 hours and has significant symptoms
unmanageable in another setting
- Other symptom management needs, supported by documentation, require frequent skilled care interventions by a nurse

- Symptoms of imminent death require a stepped up intensity of medical services and skilled nursing care.

- The patient's family is unwilling to permit other necessary skilled care or continuous care to be furnished in the home.

Roles and responsibilities of the IDT
The team should ask....

- Does the IDT's documentation “paint the picture” that supports the GIP level of care over time? Is an increase in the need for services documented?

- Did the team take all necessary steps to determine the need for GIP care?

- Was the decision individualized to the needs of this patient by the IDT?

- Is the decision consistent with the patient’s and family’s preferences? Are the preferences documented?

- Has a transfer order or form required for inpatient admission been completed?

- Has the IDT begun the plan for a safe discharge for when GIP is no longer needed? What is Plan B?

- Is there collaboration between the hospice and facility around the goals of care and the plan for discharge?

- Does the IDT’s documentation reflect communication with the attending physician and the patient and family’s goals of care?
HOSPICE OF THE NORTH SHORE, INC.

General Inpatient Level of Care Acknowledgement

Patient Name: ___________________________ ID# __________

General inpatient (GIP) hospice care is short term care in a hospital, skilled nursing facility or inpatient hospice facility (Kaplan Family Hospice House) for patients who require aggressive, intensive treatment to manage a medical crisis or symptoms that cannot be managed in the home setting.

The number of days that GIP hospice care can be provided is dependent on the reason for the admission and the patient's individual needs, but generally ranges from a few days to two weeks.

During the period the patient is receiving GIP hospice care for symptom control or crisis management, hospice benefits under the patient's health insurance (Medicare, Medicaid, Tufts Health Plan, Harvard Pilgrim Health Care and some other carriers) will pay for the inpatient stay.

The Hospice of the North Shore nurse and/or social worker will meet with family members to discuss discharge plans in the event the patient's condition improves and s/he no longer meets the criteria for GIP hospice care. Most of the time, the patient will return to the home setting, where s/he can receive hospice routine home care services.

If care at home is not feasible, options for residential care in a long-term care facility or at the Kaplan Family Hospice House can be considered. Room and board charges for residential care are the responsibility of the patient and family, unless covered by insurance. In the Kaplan Family Hospice House, a financial assessment is conducted for patients with limited funds to determine eligibility for a reduction from the standard room and board charges.

By signing below, you acknowledge that you have been informed that the patient currently meets the criteria for GIP hospice care. This level of care is meant to be short term and you will work with the Hospice of the North Shore team to develop alternative plans in the event that the patient no longer meets the criteria for GIP hospice care.

Patient or Representative: ___________________________ Date: __________

Hospice of the North Shore Representative: ___________________________ Date: __________
IN-PATIENT SERVICES AGREEMENT

This IN-PATIENT SERVICES agreement is made and entered into on this ___ day of 
___________, 20___ by and between __________________, (the “Facility”), and 
________________ Hospice (“Hospice”),

WHEREAS, Hospice operates a licensed hospice program

WHEREAS, the facility is a duly licensed facility that is certified to participate in the 
Medicare and/or Medicaid programs and is able to provide in-patient care for pain and symptom 
management

WHEREAS, Hospice wants to engage Facility, and Facility wants to be engaged, to provide 
In-Patient Services to Hospice Patients in accordance with the terms and conditions of this Agreement.

WHEREAS, the parties desire to provide a full statement of their agreement in connection with 
the provision of in-patient care at the facility to patients of the Hospice;

NOW THEREFORE, in consideration of the foregoing, the mutual promises contained herein, 
and for valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the 
parties to this Agreement hereby covenant and agree as follows:

1. **Statement of Principles**

Hospice is engaged in providing interdisciplinary care and treatment of terminally ill patients in 
order to allow these patients to continue life with minimal disruption, primarily in a home 
environment. Hospice care is palliative rather than curative. Hospice services should consist
of a close and comprehensive continuum of care from home to inpatient setting and back to home again. The parties agree to cooperate and coordinate their efforts to achieve that objective. Hospice shall retain professional management responsibility for patient care services and shall ensure that they are rendered in a safe and effective manner by persons meeting the qualifications set forth in 42 C.F.R. 418 et seq. And in accordance with the patient’s Plan of Care.

2. Definitions

The following terms shall, for purposes of this Agreement, have the meanings set forth below:

2.1 General In-Patient Care Day: a day on which a Hospice Patient receives In-patient Services for pain and symptom management which cannot be managed in other settings. Any portion of a twenty four (24) period, if less than twenty four (24) hours, will constitute a General In-Patient Day and shall be compensated pursuant to this Agreement, except the day on which the patient is discharged unless the patient dies while under the General In-Patient level of care.

2.2 Hospice Patient: an individual who has elected, directly or through his or her legal representative, to receive hospice services.

2.3 Hospice Physician: a licensed doctor of medicine or osteopathy employed or contracted by hospice who will be responsible for the oversight of the Hospice’s Hospice Physician: a licensed doctor of medicine or osteopathy employed or medical component, which may include the provision of physician services to a hospice patient.

2.4 Election Statement: A form which is filled by or on behalf of an individual who meets the eligibility requirements for Hospice Care, evidencing the individual’s
election to receive Hospice care, and which meets the requirements set forth at 42 U.S.C. 418.26.

2.5 **Hospice Services:** Services provided to a hospice patient that are deemed reasonable and necessary for the palliation and management of the hospice patient’s terminal illness and are specified in the patient’s hospice plan of care. Hospice services include; nursing care and services under the supervision of a registered nurse; medical social services provided by a qualified social worker and the direction of a physician; physician services to the extent that these services are not provided by the patient’s attending physician; counseling services which include bereavement, dietary, and spiritual counseling; physical, occupational, speech, and respiratory therapies; home health aide and homemaker services; medical supplies; drugs and biologicals; and use of medical devices deemed necessary for the provision of care.

2.6 **In-Patient Services:** In-patient beds and related services that are available at and will be provided by facility. This will include all services that may be necessary for pain or symptom management and control, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen and related ancillary services. These services will be provided without limitation.

2.7 **Medicare/Medicaid Eligible Hospice Patient:** a patient who is eligible for Medicaid or Medicare and has elected the hospice benefit; or a patient who is eligible for both Medicaid and Medicare and has elected the Medicare Part A Hospice Benefit.

2.8 **Interdisciplinary Group:** A group of Hospice employees, consisting at a minimum of a doctor of medicine, a registered nurse, a social worker, and a
counselor, and which additionally may include a volunteer Hospice Support Worker, who provide or supervise the care and services offered by the Hospice.

2.6 Plan of Care: A written plan prepared by the Primary Attending Physician, the Medical Director and the Interdisciplinary Group specifically for each Hospice patient containing and assessment of the patient’s needs, identification of services to be provided, including the management of discomfort and symptom relief and setting forth in detail the scope and frequency of services needed to meet the patient’s and family’s needs, which will be reviewed and updated at intervals specified in the Plan.

3. Obligations of the Facility

3.1 General Principles: Subject to the terms and conditions herein, and at the request of the Hospice as provided herein, the facility shall provide services to Hospice patients. Services may be provided only with the express authorization of the Hospice. The facility shall render no medical service without the attending Physician’s approval and annotation on the patient’s chart. The facility shall abide by, and provide services in compliance with the protocols established by the Hospice patient’s individual Plan of Care as developed and amended from time to time by the patient’s Attending Physician, the nursing staff of the facility, the Hospice Medical Director, and the hospice Interdisciplinary Group. Services for eligible Medicare/Medicaid hospice patients will be reimbursed by the Hospice only if provided in accordance with the Plan of Care.

3.2 Standards of Care: All services provided by facility pursuant to this Agreement shall be performed and rendered in a competent, efficient, and satisfactory
manner, in accordance with the standards of care. The Facility shall conform
with all applicable provisions of law and other rules and regulation of any and
all governmental authorities relating to licensure and regulation of facilities. The
Facility shall further abide by the patient care protocols established by the
Hospice for its patients.

3.3 **Inpatient Admission:** The Facility agrees to provide beds for use by Hospice
patients and to provide inpatient services to Hospice patients, as necessary,
according to the admitting policies set forth below. These policies are effective
on a twenty-four hour basis and will include emergency admission.

a. At the request of the patient’s Attending Physician and with the
concurrence of the Hospice Medical Director, the Facility shall admit
Hospice patients as inpatients in the Facility. A Hospice Nurse will
coordinate such admissions.

b. The Facility shall provide Hospice patients with access to beds located in
areas that are mutually agreed on by the Hospice and the Facility.

3.4 **Provision of Inpatient Services:** As specified in the Hospice Plan of Care, as it may be
modified from time to time, the Facility shall provide the following services to the
Hospice patient: Inpatient nursing care as needed; appropriate physician and other
professional services as needed; emergency services which are consistent with the
Hospice treatment plan; pharmacy, dietary, laboratory, x-ray, housekeeping services,
and all other related ancillary services.

The Facility nursing staff shall consult with the Hospice if pain and symptom
management and/or patient/family psychosocial problems arise.
3.5 **Hospice Personnel Privileges:** Upon application by the Hospice Medical Director, the Facility shall grant to the Hospice Medical Director medical staff privileges in the absence of reasonable and clear cause for denial.

The Facility shall grant to Attending Physicians temporary privileges to admit and treat Hospice patients, subject to the rules and policies governing the Facility’s medical staff.

The Facility shall allow members of the Hospice Interdisciplinary Group to have access to the medical record of a Hospice patient which is generated during the Hospice patient’s stay at the Facility, provided that the patient has consented to such access in a signed Election Statement or a signed consent form.

3.6 **Hospice Patient Privileges:** The Facility shall provide access and unrestricted visiting privileges for Hospice patients 24–hours per day, 365 days per year.

The Facility shall accommodate family members who wish to remain with the patient overnight by providing reclining chairs, cots, or other reasonable accommodations.

3.7 **Accommodations for Family Privacy After a Patient’s Death:** The Facility shall call family members after the death of a Hospice patient and offer such members the choice to visit or not to visit.

The Facility shall permit family members to stay with the body for a period which usually will not exceed four (4) hours, provided that such a stay by family members does not interfere with the provision of care to other patients within the Facility.

3.8 **Preparation and Maintenance of Medical Records:** The Facility shall prepare and maintain medical records for each Hospice patient receiving services pursuant to this Agreement. The medical records shall consist of progress notes and clinical notes describing all inpatient services and events. The Facility shall send a standard physician, nursing, and social service referral form to the Hospice on the day of discharge. The
Medical Records Department of the Facility shall send a copy of the relevant portion of the inpatient medical records to Hospice within two weeks of discharge. The Facility shall ensure that appropriate release forms are signed.

3.9 Licensure and Qualification: The Facility shall ensure that all facility personnel providing inpatient services to Hospice patients pursuant to this Agreement shall have and maintain on a current basis all licenses, certifications, and other permissions required by law to perform their services and shall comply with the Facility’s general personnel policies and health standards.

The Facility hereby warrants it is certified to participate in the Medicare program. The Facility shall immediately notify the Hospice concerning any proposed, threatened or actual revocation, termination or material modification of its certification as Medicare provider.

4. Obligations of the Hospice

4.1 General Principles: The Hospice shall assure the continuity of patient/family care in home, outpatient settings. Hospice staff will participate in the planning, provision, coordination, and evaluation of care provided to the patient during his/her facility stay. Hospice staff will work closely with inpatient staff in coordinating and facilitating appropriate discharge planning.

4.2 Rules and Regulations: Hospice shall comply and shall cause its employees, contractors and volunteers to comply with reasonable rules and regulations of the Facility to the extent that they are to superseded by this Agreement.

4.3.1 Hospice Plan of Care: The Hospice shall develop and shall periodically review and update a written Plan of Care for each Hospice patient, which shall include
an assessment of the Hospice patient’s needs and an identification of the services to be provided, including control of pain and management of other symptoms.

4.4 **Special Hospice Consultations:** Hospice shall provide a minimum the following services:

a. The Hospice Medical Director shall see the patient as needed and consult with the attending physician to establish an appropriate pain control program.

b. The Hospice nurse shall: (1) visit the patient within two business days of admission and at that time consult with the Facility’s nursing staff to assist in establishing an appropriate inpatient care plan; (2) visit the patient at least 5 to 7 times per week during the inpatient episode; (3) meet with the inpatient primary care nurse and, as appropriate, other key staff (e.g., social worker) to update the Plan of Care; and (4) consult with the Facility staff as needed regarding pain and symptom management and patient/family psychosocial issues.

c. The Hospice social worker on a given patient’s Interdisciplinary Group shall; (1) visit the patient within two business days of admission, as appropriate; (2) make additional visits as necessary; and (3) consult with the Facility’s discharge planners to ensure that an appropriate discharge plan is developed at the earliest possible time so that discharge and return to the patient’s home (or other appropriate placement, if necessary) may take place as soon as possible.

4.5 **Discharge Planning and Evaluation:** In accordance with Medicare regulations, Hospice shall assure that members of the Interdisciplinary Group (at a minimum, a Hospice nurse and social worker, in consultation with the Hospice Medical Director) review the Hospice patient’s current inpatient status and clinical record before and after
discharge and that the Hospice Interdisciplinary Group discuss this review. Hospice shall communicate any areas of concern to Facility staff.

4.6 Bereavement: Hospice shall offer the Facility staff bereavement counseling after the death of a hospice patient.

4.7 Continuing Education for the Facility Staff: Hospice retains responsibility for appropriate hospice care training of the personnel who provide care under this Agreement. Hospice shall provide continuing education programs on the care of the terminally ill patient to Facility staff.

4.8 Quality Assurance: The Facility shall cooperate with the Hospice in its hospice-wide quality assessment and performance improvement activities. Third party payers may also impose their own utilization management or quality assurance requirements, which the Facility must meet.

5. Charges, Billing, and Reimbursement for Inpatient Services

The Facility agrees that the per diem rate for Hospice patient care furnished pursuant to this Agreement shall not exceed the charge listed in Appendix A of the Agreement. This per diem rate will be reviewed on an annual basis date to be determined by both the Facility and the Hospice.

For charges incurred by Hospice inpatients for non-hospice related expenses, the Facility shall directly bill the responsible party, e.g., the patient or the third party payor, as appropriate.

Notwithstanding the foregoing, the Facility shall bill Hospice services to eligible Medicare/Medicaid Hospice patients and to any other patients where the relevant payor permits or requires Hospice to bill for inpatient services.

6. Access to Book and Records

If the value or cost of services provided under this Agreement is $10,000 or more within a twelve-month period, then, to the extent that the cost of such services is reimbursable by
Medicare to Hospice, the Facility agrees to comply and to cause its agents to comply with the access to books, documents, and records of subcontractors provisions of Section 952 of the Omnibus Reconciliation Act of 1980 (P.L. 96-499), and 42 C.F.R. Part 420, Subpart D, 420.300 et seq.

In accordance with these provisions, the Facility will, upon proper written request made in conformance with 42 C.F.R. 420.304, allow the Comptroller General of the United States, the Secretary of Health and Human Services, and their duly authorized representatives access to this Agreement and to the Facility’s book, documents, and records (as defined in 42 C.F.R. 420.301) necessary to certify the nature and extent of costs of Medicare reimbursable services provided under this Agreement. Such access will be allowed, upon request, until the expiration of four (4) years after the Medicare reimbursable services are furnished pursuant to this Agreement.

If the Facility or any organization “related to” the Facility furnishing services provided for in this Agreement pursuant to a subcontract with the Facility, are requested to disclose any books, documents, or records relevant to this Agreement for the purpose of any audit or investigation, the Facility shall notify the Hospice of the nature and scope of such request and shall make available to the Hospice all books, documents, or records that it intends to disclose pursuant to such request.

To the extent that this provision varies from any provision required by any regulation issued under authority of section 952 of P.L. 96-499, the provisions of said regulation, 42 C.F.R. Part 420, as amended, shall be deemed by the parties to supersede this provision and be made a part hereof by reference.
7. **Relationship Between the Parties**

The relationship of the parties shall be that of independent contractors, and nothing in this Agreement shall be construed to render either party a partner, employee or agent of the other, nor shall either party have authority to bind the other in any respect, it being intended that each party shall remain solely responsible for its own actions. No employee or agent of one party hereto shall be considered an employee or agent of the other party here to.

8. **Insurance**

The Facility agrees that during the term of the Agreement, it shall provide adequate professional liability insurance covering its employees, agents, and independent contractors. Likewise, the Hospice agrees that during the term of this Agreement, it shall provide its employees with adequate liability insurance and that it will supply to the Facility upon request an Insurance Certificate Indicating said coverage.

9. **Indemnification**

The Facility shall not be responsible to the Hospice for any losses or liabilities sustained as a result of Hospice’s employees; or agents malfeasance or negligence or for any claims arising out of the failure of the Hospice to institute or maintain recommended practices. Hospice agrees to save, indemnify, and hold the Facility harmless from any injury or damage that may result to any person or property by or from any acts of omissions to act by the Hospice, its agents, employees, or invitees. Likewise, the Facility agrees to save, indemnify, and hold Hospice harmless from any injury or damage that may result to any person or property by or from any acts or omission to act by the Hospital, its agents, employees, or invitees.

10. **Term and Termination**

This Agreement shall be in effect from the date hereof until ______________________.
Renewal shall be automatic for a two year period and then subject to written agreement of both parties. This Agreement may be terminated with or without cause by either party at any time by giving written notice of termination ninety (90) days in advance thereof. In addition, either party may terminate this Agreement if the other party fails to perform a material obligation within this Agreement and fails to cure such default within thirty (30) days of receiving notice of such default from the non-defaulting party.

11. Miscellaneous

11.1 Incorporation: This instrument (including any exhibits hereto) contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understanding between them with respect to the matters provided for therein.

12.2 Severability: This Agreement is severable, and in the event that any one or more of the provisions hereof shall be invalid, illegal or unenforceable, in any respect, the validity, legality, enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

12.3 Headings: The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

12.4 Applicable Law: Construction: This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts. No provisions of the Agreement shall be applied or construed in a manner that is inconsistent with applicable laws and regulations of the United States and the Commonwealth of Massachusetts.

This Agreement at all times is to be subject to applicable state, local and federal law, including but not limited to Determination of Need laws, the Social Security Act, and all Medicare regulations, including without limitation any
future regulations dealing with reimbursement, as they may from time to time be amended. The parties agree to renegotiate this Agreement in the event that a provision of the law or amendment thereto invalidates, is inconsistent with, or otherwise renders unenforceable the terms of this Agreement.

12.5 **Enforceability:** It is the explicit intention of the parties hereto that no person or entity other than the parties hereto, except governmental authorities to the extent required by law, is or shall be entitled to bring any action to enforce any provision of this Agreement against either of the parties hereto, and that the covenants, undertakings, and agreements set forth in this Agreement shall be solely for the benefit of, and shall be enforceable only by the parties hereto or their respective successors and assigns as permitted hereunder.

12.6 **Assignment:** This Agreement shall not be assignable by either party without prior written consent or the other party hereto.

12.7 **Use of Identification:** Neither the Facility nor any employee shall use the Hospice logo or name without the written consent of Hospice.

12.8 **Waiver:** Neither the waiver by either of the parties hereto of a breach of or a default under any of the provisions of this Agreement, nor the failure of either parties, on one or more occasions, to enforce any of the provisions of this Agreement or to exercise any right of privilege hereunder, shall thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights, or privileges hereunder.

12.9 **Amendment:** This Agreement may be amended by written agreement of both the parties.
12.10 **Notice:** All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement, shall be in writing, addressed as set forth below. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit of messenger or the answer back being deemed conclusive evidence of such delivery. Or at such time as delivery is refused by the addressee upon presentation. Each party may designate by notice in writing a new addressee and address to which any notice or communication may thereafter be so given or sent:

**HOSPICE:**

By: ____________________________
Printed Name: ____________________________
Title: Executive Director

______________________________
Date

**HOSPITAL:**

By: ____________________________
Printed Name: ____________________________
Title: ____________________________

______________________________
Date
HOSPICE CONTRACTING FOR THE PROVISION OF GENERAL INPATIENT CARE

October, 2005

A hospice has several important considerations to make when entering into arrangements with a hospital or skilled nursing facility for the provision of general inpatient care for hospice patients. This article will lay out the requirements contained in the Medicare Conditions of Participation ("CoPs") and the federal anti-kickback statute that must be complied with when entering into a written agreement between a hospice and a facility for the provision of general inpatient care to its patients.

General inpatient care is defined as short-term pain control or acute or chronic symptom management provided either by the hospice in its own inpatient facility or through an agreement with a hospital or long term care facility (when such care cannot be provided in the hospice setting). When a hospice does not have the ability to provide general inpatient care in its own inpatient facility, the hospice must contract with a facility that meets all of the following requirements found in the CoPs:

- The facility must participate in the Medicare or Medicaid program;
- The facility must provide 24-hour nursing services sufficient to meet total nursing needs and are in accordance with the patient's plan of care;
- The facility must be designed for the comfort and privacy of each hospice patient and his or her family, including
physical space for private patient and family visiting, accommodations for family members to remain with the patient throughout the night, accommodations for family privacy after a patient's death, and décor which is homelike in design and function; and

- The facility must allow patients to receive visitors at any hour, including children.

The CoPs require that the hospice have a legally-binding written agreement for the provision of any arranged services. This written agreement must include the following:

- Identification of the specific services to be provided and the party responsible for the implementation of the provisions under the agreement;
- The services may only be provided with the express authorization of the hospice;
- A description of the manner in which the services are to be coordinated, supervised and evaluated by the hospice;
- The delineation of the roles of the hospice and the inpatient provider in the admission process, patient/family assessment, and the interdisciplinary group care conferences;
- A requirement that documentation must be kept showing that services are provided in accordance with the agreement;
- Minimum qualifications for the personnel providing the services;
- A requirement that the hospice will furnish to the inpatient provider a copy of the patient's plan of care and specific inpatient services to be furnished;
- The inpatient provider has established policies consistent with those of the hospice and agrees to abide by patient care protocols established by the hospice for its patients;
- That the medical record for each patient include a record of all inpatient services and events; and
- A requirement that a copy of the discharge summary and, if requested, a copy of the medical record for each hospice patient must be provided to the hospice.
Additionally, as part of its overall corporate compliance plan, the hospice should ensure that the arrangement with the general inpatient provider does not violate the Federal anti-kickback statute, which makes it a criminal offense to knowingly or willfully offer, pay, solicit or receive remuneration to induce or reward referrals of items or services payable by a Federal health care program. The statute contains a safe harbor for personal services and management contracts, and if structured properly, a hospice agreement with a facility for the provision of general inpatient care could fall under this safe harbor. Full compliance with this safe harbor would immunize the arrangement from prosecution under the statute. The safe harbor requires all of the following for such an arrangement:

- The arrangement must be set forth in a written agreement;
- The agreement must cover all services to be provided by the contracting parties;
- If the agreement is intended to provide for services on a periodic or part-time basis, the agreement must specify exactly the schedule of such intervals of service, and the exact charge for such intervals;
- The agreement must be for a term of at least one year;
- The aggregate compensation under the agreement must be set out in advance, consistent with fair market value in an arms-length transaction and not determined in a manner that takes into account the volume or value of any referrals or other business otherwise generated between the parties for which payment may be made under any Federal health care program;
- The services performed under the agreement do not involve the counseling or promotion of a business arrangement in violation of the law; and
- The aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the business purpose of the services.
For hospices that do not have the facilities to provide general inpatient care for their patients, an arrangement with a hospital or long term care facility for the provision of such care is essential. A well-drafted agreement between the hospice and the facility, incorporating the requirements of the CoPs and in compliance with the personal services and management contracts safe harbor under the anti-kickback statute, is an important component in ensuring that an arrangement for the provision of general inpatient care complies with federal law.

Reinhart Boerner Van Deuren's Hospice and Palliative Care Practice Group serves hospices across the country in a variety of areas, including: regulatory compliance; survey and certification; accreditation; licensing; HIPAA; caregiver misconduct investigations; due diligence, mergers and acquisitions and other corporate matters; labor and employment; criminal and civil investigations by state or federal government agencies; litigation; contracts and daily operational issues.
CORPORATE COMPLIANCE AND PROVISION OF GENERAL INPATIENT CARE: SELECTED RISK AREAS

August, 2005

General inpatient care is an integral part of the Medicare hospice benefit. It is important that hospice patients whose care needs require this level of care receive it. It is critical that this important component of hospice care be fully utilized whenever the care needs of hospice patients require it. A hospice's under-utilization of general inpatient care can raise ethical, quality and regulatory issues. However, over-utilization can also pose risks. Because of the higher reimbursement level and the potential for allegations of anti-kickback and false claims, policies and procedures governing general inpatient care should be considered within the general context of the hospice's corporate compliance plan. A compliance plan is a health care provider's strategy to establish a culture within the organization that promotes prevention, detection and resolution of instances of conduct that do not conform to federal and state law, especially in the areas of fraud and abuse, federal, state and private payor health care program requirements and the organization's own ethical and business policies. A corporate compliance plan follows the U.S. Sentencing Guidelines and provides a definition of what constitutes an "effective program to prevent and detect violations of the law." There are seven minimum elements of an effective compliance plan and they are as follows:

1. Written standards of conduct and written policies and procedures.

2. Development of a compliance team, including a compliance officer.
3. Education and training.

4. Effective lines of communication.

5. Discipline policies that reflect compliance concerns.

6. An audit and monitoring procedure.

7. A mechanism for investigating and correcting problems.

A hospice that develops, implements and continues to refine its corporate compliance program will be better able to ensure its compliance with conditions of participation as well as payment issues and fraud and abuse laws.

The question of inpatient care implicates a number of the risk areas specific to hospices as set forth in the OIG Compliance Program Guidance for Hospices. Following is a summary of those risk areas:

1. **Hospice incentives to actual or potential referral sources** (e.g., physicians, nursing homes, hospitals, patients, etc. that may violate the anti-kickback statute or other similar federal or state statute or regulation, including improper arrangements with nursing homes).

The practice of admitting hospitalized patients and keeping them in the hospital is permissible. An individual who is eligible for the hospice benefit and chooses hospice care should receive hospice, whatever their required care level. However, a practice of offering a hospital compensation for hospice patients after the DRG has run out and promising the hospital and/or the hospice patient that they may remain in the hospital indefinitely poses a risk for the hospice. If it appears that the hospice is offering something of value as an inducement to obtain referrals from the hospital (or directly from the beneficiary), there is a possibility of an anti-kickback violation. Only those patients who clearly need general inpatient care should receive it. This medical necessity should be well documented by the IDG.
If the hospice provides general inpatient care in a skilled nursing facility, the relationship between the hospice and the nursing home must be carefully reviewed. The OIG Compliance Program Guidance for Hospices and the OIG Compliance Program Guidance for Nursing Homes both emphasize the OIG's concerns regarding possible abuse in such relationships. If, for example, the hospice contracts with a skilled nursing facility for the provision of general inpatient care and provides staffing to the skilled nursing facility to ensure 24-hour RN coverage, there may be an inference of an unfair inducement to refer. Likewise, if the SNF is receiving the full general inpatient Medicare payment and the general inpatient care is not clearly documented by the hospice, it too could be seen as an impermissible inducement to refer.

It should be noted that a hospice incentive to a patient is also a potential violation of the anti-kickback statute. If the patient and the patient's family are told that they may remain in the hospital, for example, if they sign up for the hospice benefit, that might be considered to be an unfair inducement to refer.

2. **Billing for a higher level of care than was necessary.**

The OIG makes clear that if only routine home care is needed, billing for general inpatient care constitutes fraud. In addition to recoupment issues, this practice may implicate federal fraud laws with their attendant penalties. A hospice that has its own inpatient facility may find that the percentage of general inpatient days in the hospice has multiplied. While this is not necessarily a violation (and may be very appropriate in ensuring access to appropriate hospice care), it is an important area for scrutiny within the context of the hospice's corporate compliance plan. An increase in general inpatient care days should be carefully audited by the hospice to ensure that documentation is clear and that the general inpatient level of benefits is clinically justified.

3. **General inpatient care in skilled nursing facilities: specific issues.**

As it becomes more difficult for hospices to contract with hospitals for the general inpatient benefit, more hospices are entering into contracts with skilled nursing facilities for the general
inpatient level of care. As set forth above, the provision of general inpatient care in SNF should be carefully reviewed as part of the hospice's overall corporate compliance plan. Not all SNFs are capable of providing the general inpatient level of care and it is therefore suggested that the template hospice/nursing home contract for routine home care be separated from the general inpatient contract. In deciding whether a particular SNF is capable of providing that level of care, hospices are advised to carefully review the tools that have been developed by NHPCO, in particular *Hospice in Nursing Facilities*. The importance of communication and careful due diligence on the part of the hospice in entering into such agreements cannot be overstated. A SNF that is substandard or does not include 24-hour RN coverage poses significant risks from the standpoint of patient care, professional liability and regulatory compliance. Further, a hospice that contracts with a SNF to provide GIP care and then discharges the patient (or has the patient revoke) when only routine home care is needed, runs the risk of regulatory scrutiny. Following is the checklist of conditions of participation for all provider contracting. As with all such contracts, the importance of clear protocols, policies and procedures and ongoing communications is key.

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The analysis of fraud and anti-kickback prohibitions is very complex and depends on the individual fact situation. For example, it is permissible for the hospice to accept patients who are in the hospital and provide general inpatient care until the patients are ready to go home under the routine home care benefit if the hospice clearly documents the clinical justification for its decision. However, if the hospice also provides pain consults to any hospital patient at no charge and otherwise assists the hospital in providing care to hospital patients, the overall relationship may be suspect. It is important for hospices to carefully review all of their policies and procedures and to create an environment within the hospice whereby those policies and procedures are consistently implemented in compliance with federal and state laws and regulations. Since general inpatient care is increasing so dramatically, we can expect that it will be an ongoing area of scrutiny by fiscal intermediaries and by the OIG itself. Potential penalties and consequences for failure to follow the requirements include forfeitures, civil judgments and penalties, restitution as well as fines and imprisonment. The benefits of
reviewing all hospice program elements include not only the minimization of the risk of violating the law but also the mitigation of any consequences of any violations that do occur and reduction in the likelihood of whistleblower suits. A hospice that develops and maintains a clear corporate compliance plan promotes its reputation as a good corporate citizen, protects its officers and directors from liability and allows itself to assess all of its business relationships with other providers. The increase in general inpatient days may be valid, given the totality of the circumstances in an individual hospice. Because it is increasingly an area of scrutiny for fiscal intermediaries, the need for a higher level of care should be carefully documented and audited by the hospice itself.

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Appendix G

Physician and Nurse Practitioner Billing for the General Inpatient Level of Care

Q. **How does a physician consultant bill if the patient is on the GIP benefit?**
A. If the consult is regarding the hospice diagnosis, then the consultant directly bills the Hospice (a contract would have to be established with set rate of reimbursement.) If the consult is regarding a non-hospice diagnosis, then the consultant bills Medicare Part B with a GW modifier.

Q. **What happens if a different non-hospice employed physician becomes the attending physician when a patient is on the general inpatient benefit?**
A. The hospice must ensure that the Attending of Record is changed in the record so that the Attending can bill effectively.

Q. **How does the Hospice Medical Director bill if NOT the attending physician, but acting as a consultant for a patient on the GIP benefit?**
A. If the Hospice Medical Director is providing direct care related to the terminal diagnosis upon the request of the Attending Physician, the hospice physician bills Part A using appropriate codes.

Q. **Can a Nurse Practitioner (NP) bill for services provided to a patient on the GIP benefit?**
A. Yes, if the following conditions are met: the patient is a Medicare patient, the nurse practitioner is the Attending of Record, and the services are medically reasonable and necessary (cannot be performed by an RN). NPs can only bill for the services of NPs provided to patients for whom they are the Attending of Record. They can not bill for covering services for patients that have another attending whether an NP or an MD. Not NPs will be paid at 85 percent of the physician fee schedule. NP’s cannot sign the certification of terminal illness.

**Resources:**
- CMS Transmittal R205CP
- NHPCO Web Seminar Billing for Hospice and Palliative Care Physician Services, 2007
- 42 CFR 418.304
- Federal Register August 4, 2005, pages 45139-45140
Hospice Benefit Facility Reimbursement Form

Name of Resident: ____________________________

☐ Hospice Admission  ☐ Change in Hospice Level of Care  Effective: ___________

Payment Source:  ☐ Medicare: policy # ____________________________

☐ MassHealth: policy # ____________________________

☐ Other: ____________________________ policy # ____________________________

Check which applies:

1. MassHealth Room and Board
   • Hospice will be billed for room and board
   • Hospice will provide medical supplies, equipment, and medications that are related to the hospice diagnosis

2. MassHealth Pending
   • Facility to bill patient for room and board if MassHealth application is denied
   • Hospice will be billed for room and board once MassHealth authorization is received
   • Hospice will provide medical supplies, equipment, and medications that are related to the hospice diagnosis

3. Private Pay
   • Facility to bill patient for room and board, and drugs not identified on the hospice medication coverage form
   • Hospice is responsible for medical supplies, equipment and medications that are related to the hospice diagnosis

4. General Inpatient
   • Hospice should be billed the negotiated rate of ________ per day. This rate is an all-inclusive rate and covers the costs related to the patient’s hospice diagnosis (medical supplies, equipment, medications, lab tests, x-ray, etc.).

5. Respite
   • Begin Date: ____________  End Date: ____________
   • Hospice will provide medical supplies, equipment and medications that are related to the hospice diagnosis
Appendix I.

Other Requirements and Standards
for General Inpatient Units

References

Massachusetts Hospice Conditions of Participation 42 CFR Section 418
418.100(b) Disaster preparedness
418.100(c) Health and safety laws
418.100(d) Fire protection
418.100(e)-(g) Patient areas
418.100 (j) Meal service, menu planning, supervision
418.100(k) Pharmaceutical services

Massachusetts Hospice Licensure Regulations 105 CMR
141.201 (E)(2) Incident Reporting
141.299(H)(4) Building and physical plant
141.299(H)(d) Infection control
141.299(H)(e) Dietary services
141.299 Appendix A: General Standards of Construction: Hospice Inpatient Facility

Directly Owned and Operated by a Hospice Program

National Hospice & Palliative Care Organization Standards, 2006

Appendix I: Hospice Inpatient Facility (applicable to hospices that operate an owned or leased inpatient facility intended to provide hospice patients with the general inpatient level of care)

HIF PFC 3 Nutritional Needs
HIF PFC 4 Medications and Treatment
HIF PFC 5 Post mortem procedures
HIF CES 1 Physical space
HIF CES 1.6 Infection control
HIF CES 2 Disaster planning
HIF CES 3 Federal, state and local laws
HIF CES 4 Storage of drugs and medications
HIF CES 5 Security and safety

Community Hospice Accreditation Program (CHAP)
See Sections III.8c - Section HI.8f
HII.8c-8f Physical plant
HII.8f(4)&8i Nutrition
HII.8f(5) Post-mortem procedures
HII.8g-8h Infection control
HII.8j Accountability for drugs and biologicals
§ 418.108 Condition of participation: Short-term inpatient care.

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

(a) Standard: Inpatient care for symptom management and pain control. Inpatient care for pain control and symptom management must be provided in one of the following:

(1) A Medicare-certified hospice that meets the conditions of participation for providing inpatient care as specified in § 418.110.

(2) A Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (c) regarding 24-hour nursing services and patient areas.

(b) Standard: Inpatient care for respite purposes.

Inpatient care for respite purposes must be provided by one of the following:

(1) A provider specified in paragraph (a) of this section.

(2) A Medicare or Medicaid-certified nursing facility that also meets the standards specified in § 418.110(f).

(2) The facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient’s plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(c) Standard: Inpatient care provided under arrangements. If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a written agreement, coordinated by the hospice, and at a minimum specifies—

(1) That the hospice supplies the inpatient provider a copy of the patient’s plan of care and specifies the inpatient services to be furnished;

(2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients;

(3) That the hospice patient’s inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility; that a copy of the discharge summary be provided to the hospice at the time of discharge; and that a copy of the inpatient clinical record is available to the hospice at the time of discharge;

(4) That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement;

(5) That the hospice retains responsibility for ensuring that the training of personnel who will be providing the patient’s care in the inpatient facility has been provided and that a description of the training and the names of those giving the training are documented; and

(6) A method for verifying that the requirements in paragraphs (c)(1) through (c)(5) of this section are met.

(d) Standard: Inpatient care limitation. The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.

(e) Standard: Exemption from limitation. Before October 1, 1986, any hospice that began operation before January 1, 1975, is not subject to the limitation specified in paragraph (d) of this section.

§ 418.110 Condition of participation: Hospices that provide inpatient care directly.

A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:

(a) Standard: Staffing. The hospice is responsible for ensuring that staffing for all services reflects the volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.

(b) Standard: Twenty-four hour nursing services. (1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient’s plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

Implementation deadline, December 2, 2008.