

What Physicians Should Know About Hospice

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ABSTRACT

Hospice is both a philosophy and a system of care that attends to the physical, psychosocial, and spiritual needs of patients at the end of life as well as family members. The author details hospice care as it exists in the United States, focusing on topics such as levels of care provided and by whom, Medicare coverage, the roles of physicians and other practitioners, and special issues in hospice care.

INTRODUCTION

Hospice is an organized system of care for people approaching death, and it is a philosophy within which personal and medical goals are reevaluated, prioritized, and actualized with the end of life in view. Palliative care recognizes and treats the multidimensional suffering of patients with severe and life-threatening illness and encompasses the care of loved ones and caregivers as well. Hospice organizations provide palliative care for patients judged to be within 6 months of death. Thus, the terms palliative care and hospice care differ in that hospice implies a significantly limited prognosis while palliative care does not.

In 2009, 1.5 million Americans received hospice care. Cancer accounted for fewer than half of the diagnoses. During that year, two-thirds of the patients died and one-sixth were discharged from hospice. The median stay was 21 days; the mean was 70. Just

less than 12% remained in hospice care longer than 6 months.¹

The first hospice in America opened in Connecticut in 1974, associated with Yale University and funded by the National Cancer Institute. Congress authorized the Medicare hospice benefit in 1982, with goals of improved end-of-life care, primarily for cancer patients, and revenue neutrality.

Medicare Part A pays for care for more than 80% of hospice patients. State Medicaid hospice programs and other public and private insurers provide for the remainder. A tiny fraction involves charity support and self-paying patients. Medicaid and private health insurance hospice benefits are modeled on the Medicare program, which serves as the main reference for the following discussion.

WHO IS ELIGIBLE FOR THE MEDICARE HOSPICE BENEFIT?

A patient is eligible who

- has Medicare Part A
- is considered by two physicians to be within 6 months of death if the disease follows its normal course
- has chosen directly or through surrogates to focus medical care on comfort, forgoing curative therapies if such are even available.

The patient need not have pain or otherwise be suffering. There is no requirement to decline resuscitative efforts. Technologic feeding, such as via gastrostomy tube, may remain.

HOW IS THE HOSPICE PAID?

Reimbursement is per diem for 1 of 4 levels of care and includes the personal services of a licensed nurse, home health aide, social worker, and spiritual counselor. Coverage includes all medications for comfort and treatment of the hospice diagnosis, durable medical equipment such as a hospital bed, oxygen (documentation of hypoxemia is not required), a wheelchair, and the services of a dietician if needed. Direct clinical care by a hospice-employed physician is frequently available but not mandated. Some hospices provide massage and aromatherapies for their patients. Rehabilitative therapies, antibiotics for intercurrent infections,

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palliative radiation, parenteral hydration, and blood product administration are options provided or contracted for by the hospice from the per diem reimbursement in certain circumstances.

The 4 levels of care are

1. Routine care: Delivered at the patient's residence (96%).
2. Continuous care: Brief, intense services at the place of residence with a licensed nurse who is present continuously at a time of crisis, such as severe new or exacerbated symptoms or caregiver loss or breakdown (1%).
3. Inpatient care: Brief, intense services provided in a hospital, free-standing inpatient hospice, long-term acute care hospital, or skilled nursing facility for severe symptoms that cannot be controlled in the home setting or for caregiver loss or breakdown (3%).
4. Respite care: Five days of care in each certification period in a contracted appropriate facility or with full-time caregivers provided in the home by the hospice.

Because inpatient care is so highly reimbursed, Medicare requires that no more than 20% of a hospice organization's patients be at the inpatient level and occasionally requires payback from a hospice that consistently exceeds this percentage.

HOW ARE PHYSICIANS INVOLVED IN HOSPICE CARE?

The referring physician may be the attending physician or another specialist, such as a hospitalist, who estimates that the patient's prognosis is appropriately limited and who discusses the referral with the patient.

The attending physician listed with the hospice who is not a hospice employee or volunteer may have intense or minimal involvement with the hospice patient. For necessary care related to the hospice diagnosis, the attending physician may bill Medicare Part B for evaluation and management (E and M) services with the code GV. However, Medicare does not cover ancillary costs such as laboratory and radiology. Prior to the need for these services, ancillary costs can be negotiated with the hospice. Similarly, referrals to consultants may not be reimbursed unless prearranged with the hospice, which may agree to provide payment.

E and M services provided by the attending physician but not related to the hospice diagnosis are covered when billed to Medicare Part B with the code GW or the condition code 07.

The hospice keeps the attending physician's office apprised of changes in the patient's status on a

regular basis and welcomes collaboration in the patient's care. The attending physician or the hospice medical director usually signs the death certificate.

The hospice medical director provides administrative and educational services to the hospice organization and may attend the multidisciplinary team conference every 14 days as the required physician member. The director or another physician employed by the hospice must attest to each patient's eligibility for hospice initially and at each recertification period. The first 2 certification periods are 90 days each; subsequent periods are 60 days.

A hospice may employ or contract with other physicians to provide clinical and other services such as radiation, management of implanted opioid reservoirs, and deactivation of defibrillators.

Beginning in 2011, a hospice physician or contracted nurse practitioner must evaluate each hospice patient who receives services for more than the initial 6 months in a face-to-face encounter prior to each recertification. Such encounters are not separately reimbursed by Medicare. Rather than relying solely on the reports of the licensed nurses, the physician uses this personal encounter to provide the prognostic basis for recertification.

The hospice pays the medical director and other employed providers from the per diem reimbursement and may pay additionally for necessary clinical encounters for which hospice, not the physician, bills Medicare.

HOW IS PROGNOSIS DETERMINED FOR THE PURPOSE OF HOSPICE ELIGIBILITY?

It is said that if a doctor would not be surprised to learn that a particular patient has died, it would be appropriate to at least consider a hospice referral.

Hospice eligibility depends on a prognosis of 6 months or less if the disease runs its natural or expected course. Recently, limited studies indicate that at least in certain disease states, palliative care itself may be a disease modifier and extend the lifespan. In August 2010, Temel and colleagues² reported in the *New England Journal of Medicine* that newly diagnosed patients with metastatic non-small-cell lung cancer who began specific cancer therapy and palliative care simultaneously and who survived more than 12 weeks lived more than 2.5 months longer on average than those treated with similar oncologic regimens but without palliative care. Additionally, the researchers found improved quality-of-life indices and less depression than in those not offered palliative care initially. Other studies have suggested similar extended prognoses for patients with congestive heart failure and pancreatic cancer.³

Although far from precise, prognosis in malignant disease has been more intensely studied and accepted

with less questioning than prognosis in chronic non-malignant but fatal conditions such as the neurodegenerative disorders; AIDS; severe developmental disabilities of childhood; and chronic cardiac, pulmonary, liver, and kidney diseases.

Fear of being accused of Medicare fraud by attesting incorrectly to a limited prognosis probably keeps many honest and caring physicians from appropriate, timely referral for the hospice benefits to which patients are entitled. However, the Medicare Claims Processing Manual, Chapter 11 (revised in April 2010) advises fiscal intermediaries, "It should be noted that predicting life expectancy is not always exact."⁴ Incorrect prognoses made in good faith do not serve as the basis for fraud investigations.

A physician who is considering a hospice referral but is unsure of prognosis may, if the patient agrees, consult a palliative care specialist or a hospice organization for an opinion about hospice eligibility. If the patient is not eligible for hospice, a recommendation for other care options may result.

Fifteen years ago, the National Hospice Organization (now the National Hospice and Palliative Care Organization) published criteria indicating the end of natural courses for several chronic diseases.⁵ In general, the criteria combine disease-specific indicators with patient-specific functional variables such as the Karnofsky scale and individual factors such as weight loss, frequency of hospitalizations, and emergency room visits. These criteria are imprecise, but better evidence has not superseded them in most cases despite the many advancements in therapy for the nonterminal phases of these chronic illnesses. Fiscal intermediaries generally accept the guidelines as a basis for initiating and maintaining hospice service.

WHO PROVIDES THE DIRECT HOSPICE CARE?

Licensed nurses, home health aides, master's-level social workers, dietitians, spiritual and bereavement counselors, and volunteers are all active in hospice care. A hospice physician or medical director is available for consultation and liaison with attending and consulting physicians. The hospice physician is increasingly directly involved in the clinical care of complex issues or becomes involved at the patient's or family's request. The consultant pharmacist does not provide direct patient care but is an invaluable aid when parenteral opioids or sedatives are being considered or when the usual routes of administration are unavailable and special compounding provides alternatives.

HOW IS BEREAVEMENT ADDRESSED?

Medicare requires that for a minimum of 13 months following the patient's death, members of the hospice

staff keep in contact with the bereaved and provide or refer to professional counseling those whose grief seems unusually severe or unremitting. Loved ones, in addition to family and significant others, might include nursing home nurses and aides, private sitters, and dear friends. Hospices participate in community bereavement activities as well.

DO HOSPICE ORGANIZATIONS INCLUDE CHILDREN?

Some hospices have the expertise to include children who have severe developmental disabilities, cancer, or, occasionally, untreatable heart defects or other congenital aberrations, but most do not. Usually only specialty pediatric hospices, ones affiliated with a children's hospital, or a very large general hospice can amass the professional and other resources to appropriately care for terminally ill children.

WHERE DO NURSE PRACTITIONERS FIT IN?

A nurse practitioner may serve as an attending for Medicare purposes but is not currently able to certify a patient's limited prognosis. However, a revision to allow certification by a nurse practitioner is up for comment. A nurse practitioner may make the face-to-face home visit upon which the physician bases recertification for hospice patients who have passed the first 6 months of the hospice benefit.

ARE THERE SPECIAL ISSUES IN PALLIATIVE CARE AS DEATH APPROACHES?

Recognizing with the patient and loved ones when death is close and helping them to prepare for it physically, emotionally, and spiritually are among the most rewarding aspects of hospice care. Weeks of observing, listening, treating, and counseling culminate in the comfort of the patient and the loved ones in the final days.

Preparation might be as dramatic as suggesting a stockpile of dark towels to be kept near a patient who may hemorrhage near death or as subtle as noting a slight change in vital signs or the beginning of skin mottling so those further away can come to the bedside.

Few issues are as controversial as terminal sedation that can be used to relieve otherwise intractable symptoms such as intolerable pain, shortness of breath, nausea, agitation, or existential agony near the end of life. In practice, terminal sedation involves medication administration to achieve an anesthetized state for symptom relief; it can be achieved in the home setting. Some claim that this type of sedation shortens life and liken it to euthanasia. Terminal sedation is defended on the grounds that it is used for symptom relief and not to shorten life, which may occur as an unintentional side effect or dual effect.

If a hospice or attending physician believes terminal sedation might eventually be helpful, its use should be discussed with the patient or the designated decision-maker early in the care planning process and the decision for or against it should be thoroughly documented. If terminal sedation has been agreed upon and successfully instituted, it may be wise to lighten the sedation briefly after 2 to 3 days to ascertain whether or not it was and remains necessary.

IS THE HOSPICE MEDICARE BENEFIT REVENUE NEUTRAL?

Most cost/benefit analyses favor either traditional care or hospice care by a small margin. Thus, at this point, hospice is generally considered revenue neutral as it was designed to be. Hospice is cost effective for the 88% of patients who die within 6 months, but not for the 12% who remain with hospice beyond that period, sometimes as long as 2 or more years. Savings accrue from decreased care in the emergency room, intensive care, and hospital in general, but per diem payments for prolonged periods are also expensive. Issues related to end of life became political lightning rods when healthcare reform drew prominent national attention in 2009-2010. As a result, hospice will most likely not play a prominent role in proposed healthcare savings discussions. Nonetheless, improved quality at the end of life can go hand in hand with financial savings if more patients are recognized as being within weeks or months of death so appropriate discussions and hospice referrals are not delayed.

CONCLUSION

Medicare Part A pays for care for more than 80% of hospice patients. A physician certifies hospice eligibility based on a prognosis of 6 months or less, and direct patient care is provided by nurses, home health aides, social workers, dietitians, counselors, and volunteers. In addition to providing care for terminally ill patients, hospice also provides bereavement counseling or referral. This system of care focuses not only on the physical needs, but also on the psychosocial and spiritual needs of patients and their loved ones.

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