Palliative Care Review

Understanding and Using the Hospice Benefit

What is "Hospice"?

In the US, hospice is a health care system established by the government about 30 years ago as an entitlement under Medicare and Medicaid. Structured as the first managed care benefit in this country, the aim of this health system is to provide specialist-level palliative care primarily at home or in nursing homes to patients with far advanced illness and their families.

What is the "Hospice Benefit"?

The Hospice Benefit under both Medicare and Medicaid provides capitated reimbursement to certified agencies for a package of services related to the terminal illness. Hospice is also available through most commercial insurances.

What services does hospice provide?

The following services are provided at no cost to the patient or family:

- Access to an interdisciplinary team (physician, nurse, social worker and chaplain) for management of all problems related to the terminal illness
- Access to drugs, supplies and equipment related to the terminal illness
- Access to other services including volunteer support and home health aides
- Bereavement services for 13 months after the death of the patient
- In the hospital, hospice patients have access to additional nursing, social worker and chaplain services, and the support of a Hospice Medical Director.

How do patients get hospice services?

The hospice benefit must be elected by an eligible patient or by the patient's legally authorized representative. Eligibility requires physician certification of terminal illness, defined as a prognosis of 6 months or less if the illness (the primary diagnosis and comorbidities) runs its normal course. Prior to the first benefit period, a Hospice Medical Director and, if available, another physician must certify. There are two 90-day benefit periods, followed by an unlimited number of 60-day periods. Prior to each period after the first, recertification must be done by the Hospice Medical Director.

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What role does the physician play in hospice?

- Each hospice patient has an assigned Hospice Medical Director.
- After a physician refers a patient to hospice and certifies the terminal illness, he or she may (or may not) remain the attending of record; in this role, the physician agrees to assume primary management of the terminal illness, in collaboration with the Hospice Medical Director.

Any physician, including the physician who referred the patient to hospice, can be a consultant, as long as the services provided are part of the hospice plan of care.

How does physician reimbursement work after a patient elects hospice?

- If any physician cares for a problem unrelated to the terminal illness, the physician bills Medicare or the insurance company as usual; Medicare requires a code (GW code following the procedure code) to ensure reimbursement.
- If the physician who is designated the attending of record cares for a problem related to the terminal diagnosis, the physician bills Medicare or the insurance company as usual; Medicare requires a code (GV code following the procedure code) to ensure reimbursement.
- If a consultant cares for a problem related to the terminal diagnosis, the physician must bill the hospice agency; all physicians serving as consultants must sign a one-time agreement with the hospice prior to billing.

What about hospitalization for a problem unrelated to the terminal illness?

If the patient is hospitalized for a problem unrelated to the terminal illness, the acute hospital care is provided, and reimbursed, as if the patient is not a hospice patient. The patient actually remains a hospice patient, however, and the plan of care related to the terminal illness cannot be changed without discussion with the hospice. If the hospitalization is related to the terminal illness, the hospice agency is responsible for the cost, as stipulated by a contract between the hospital and hospice.

What are some myths that result in late or no referral for the hospice benefit?

Myth: “The purpose of hospice is solely to provide for a ‘good death.’

- **Fact:** Hospice is a program that provides specialist-level palliative care in the home for eligible patients. Its goal is to reduce illness burden and suffering for the patient and family. Relief of the suffering associated with the imminent death of the patient is a goal, but the program can provide much more if referral is early enough in the course of the illness.

Myth: “The patient who is thought to be hospice eligible should be told that the program is for end-of-life care, or care for the dying, because this is the honest approach.”

- **Fact:** The patient should be told that hospice is a program that provides helpful services at home, at no cost to the patient or family. Thinking that hospice is only about dying is a misconception. Although eligibility does require the physician to certify that the patient is terminally ill,

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prognosis is difficult to determine and patients may continue to get this benefit indefinitely as long as a physician can continue to certify eligibility.

Myth: "The family and patient aren't ready to hear about hospice; they haven't acknowledged that the patient is dying."

- **Fact:** Eligibility does not require this. The patient or surrogate only must acknowledge that the disease is terminal and that the benefit can continue only if a physician certifies that the prognosis continues to be limited.

Myth: "Hospice isn't appropriate because the patient still wants 'active' treatment, 'treatment for the disease,' or 'life-sustaining treatment', or the physician still wants to offer this."

- **Fact:** Disease-modifying therapies are permitted under hospice, but only if they do not change prognosis enough to negate eligibility and only if the hospice considers them within the scope of practice. When patients are eligible but receiving disease-modifying therapies, the case should be discussed with the Hospice Medical Director, or a request should be made for a "pre-election" consultation by the hospice.

Myth: "The patient needs a DNR order and a 24-hour responsible caregiver to be eligible for Hospice."

- **Fact:** Neither a DNR order nor a caregiver is required.

Myth: "There's no point to hospice because the patient is imminently dying, already in coma…"

- **Fact:** It may be true that the patient cannot benefit from hospice services, but the family is eligible for 13 months of bereavement support at no cost. This support is denied the family unless there is a hospice referral.

Visit the CCB-MJHS Palliative Care Project website at
ThePalliativeProject.org

For further information about these educational activities,
please email **PalliativeInstitute@mjhs.org** or call **(212) 649-5500.**

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