

Issues on Care at the End of Life

Hospice 101 for Physicians

More and more physicians are becoming familiar with hospice services and the benefit to their patients. Physicians now understand how much hospice can help them directly as they care for patients at the end of life. As a result, referrals to Hospice of Wake County (HOWC) have increased in the last six months and our Hospice daily census has risen from 125 a year ago to the current level of 180 patients per day. This article is presented to review some of the essentials of hospice care including the opportunities and responsibilities of the attending physician as well as the billing procedures associated with hospice care.

To review: "Hospice is comprehensive and coordinated care for patients with limited life expectancy, provided both at home and in institutional settings. Hospice care is based on a "biopsychosocial" model rather than a "disease" model of care. The essential philosophy of hospice care is the focus on comfort, dignity, and personal growth at life's end. This encompasses biomedical, psychosocial, and spiritual aspects of the dying experience, emphasizing quality of life and healing or strengthening interpersonal relationships rather than prolonging the dying process at any and all cost. Hospice care also supports the well being of those (usually family members) in caregiving roles and provides bereavement care for survivors, both during the dying process and after the death occurs." (P. Fine, www.medscape.com, 9/3/04)

Hospice of Wake County, like most other hospices, was created by a grassroots movement initiated by interested Wake County citizens including health professionals. Our country has seen the expansion of this movement through the creation of now over 3300 hospices serving over 950,000 patients in the last year of record, 2003. The Medicare Hospice Benefit (MHB), created in 1982, gave a needed boost to the awareness of the needs of the terminally ill by providing a financial mechanism by which patients can receive medical services. This benefit

pays for all the costs attributable to the terminal diagnosis including durable medical equipment and medications and on-site nursing, social work, chaplain, home health aide, dietician, and appropriate physical therapy. Like most non-profit hospices, HOWC is indebted to the many volunteers who help with the provision of care to these patients. Payment is made on a per diem basis to the hospice and must also cover all administration expenses and follow-up bereavement care to the family during the following 13 months after the death of the patient. Medicaid and most major medical insurance plans provide similar coverage for these services.

Eligibility criteria for these services are that a patient must be terminally ill with a life expectancy of 6 months or less if the disease follows its natural course, the patient must choose to receive hospice care rather than curative or life-prolonging treatments, and the patient must have Medicare Part A coverage. The 6-month expectancy certification is based on the combination of the physician's best clinical judgment and Local Coverage Determinations for Hospice Eligibility. These determination guidelines were developed by the National Hospice and Palliative Care Organization and are available in a down-loadable PDF format from the HOWC website, www.hospiceofwake.org , to assist physicians in this type of prognostication. Contrary to popular belief, the MHB and HOWC do not require that patients have DNR orders in order to qualify for services.

It is worth noting that Medicare costs for patient care under hospice are generally lower than for a comparable population without hospice care. (Pyenson et al., J Pain & Sx Mgt., Sept, 2004) It is also worth noting that terminally ill patients who receive end-of-life care from for-profit hospices receive a full range of services only half the time compared with patients treated by nonprofit hospice organizations. Bereavement services and the presence of volunteers were lacking in many for-profit hospices. (Med. Care. 2004; 432-38)

Most hospice referrals are made by physicians through their nurses or through social workers and discharge planners from the hospital. A handful of referrals come from families themselves. In both situations, the attending physician plays the key role in medical decision-making and becomes the quarterback of patient care management. The relationship between the attending and the hospice can best be compared to that with a hospital or nursing home: orders come from the physician; they are recorded and carried out by a registered nurse, and then signed later by the physician, usually through fax communication. When a patient is admitted, he or she will be seen on a regular basis by the RN case manager, one to three times or more per week depending on the clinical stability of the patient. In those patients where critical changes are occurring more frequently, the nurse may see the patient once or twice daily. The RN case manager will usually report to the physician on a scheduled frequency requested by the physician. A group of professionals review the patient every two weeks in an Interdisciplinary Team Meeting consisting of a hospice physician, a pharmacist, and the patient's nurse, social worker, and chaplain. Deliberations from these meetings may result in recommendations to the attending for her or his approval. The hospice medical director may assume care for a patient at the request of the attending; however, hospices generally encourage the attending to maintain their relationship with their patient at this crucial time in the patient's illness.

While caring for the patient, the attending may continue to see her or him at home, in the nursing home and hospital, or in the office and then bill according to the standard evaluation and management (E&M) CPT codes. Four levels of hospice care are available: routine home care, continuous home care, respite care, and general inpatient care. Billing Medicare by the attending physician is done through Medicare Part B as opposed to billing for services by the hospice, which is through Medicare Part A. Payment for services is made directly to the physician at 80% of the Medicare reasonable charge. Hospice patients are responsible to the physician for the usual Medicare co-pay just as a non-hospice patient would be. Hospice programs must notify the Medicare Part B carrier that

the physician has been designated as the hospice patient's attending physician so that he or she will receive payment for submitted charges. Technical services, such as x-rays and laboratory tests, performed by a physician or other healthcare professional are covered in the program's per diem rate. (AAHPM Physician self-study Program, UNIPAC ONE, 2003) (See Table 1)

Table 1: Summary Chart for Physician Billing

Description of Service	Bill Medicare Part B	*Bill Hospice: Hospice Bills Intermediary and Reimburses Physician	*Bill Hospice: Covered under Hospice Benefit per Diem
Attending Physician Professional services	√		
Covering (stand in) Physician Professional services	√		
Consulting Physician Professional services		√	
Hospice Medical Director (or other Hospice physician) Professional services Administrative services Technical services		√	√ √

If the attending wishes to refer the patient to a consultant for evaluation and treatment of a condition related to the terminal diagnosis, approval must first be obtained from the hospice and the consultant must have a contractual relationship with the hospice, much like existing rules for other insurance agencies. The consultant then bills the hospice directly for services rendered. These methods of coding and billing largely prevent rejection of claims by Medicare and other insurance companies. Questions about billing problems should be brought to the attention of the CFO of the hospice.

The goal of hospice is to maximize the quality of *living* during the last stages of life. Although it emphasizes dying well, there is a strong emphasis on living well in the time that a patient has remaining. Singer and colleagues (JAMA. 1999; 281: 163-8) have identified 5 factors that terminally ill patients felt were most important in their care:

1. Relief from unpleasant symptoms
2. Avoidance of a prolonged dying process
3. Control over care decisions
4. Relieving loved ones of excessive burdens of care
5. Strengthening relationships with loved ones

The physicians who attend to the care of their patients at the end of life can make positive contributions not only to the quality of their patients' lives but also to the quality of the family's memories of the passing of their loved one.