

Medicare Hospice Benefit III: Special Interventions

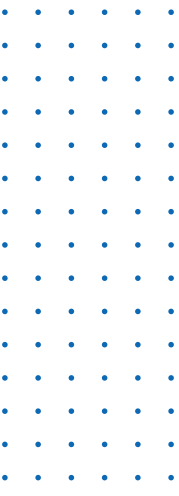
Robin Turner MD, Drew A Rosielle MD

This Fast Fact will discuss the use of interventions in hospice care that can be controversial due to high cost and/or uncertainty whether they constitute 'palliative' interventions. When a patient elects the Medicare Hospice Benefit (MHB), the patient, the doctor, and the hospice team develop a Plan of Care (POC) that lists a) the patient's goals for care and b) the services needed to achieve these goals. A hospice program is fiscally responsible for all services outlined in the POC, and these services are paid for from the pool of money the hospice program gets from per diem payments (physician fees are billed separately – see Medicare Hospice Benefit Part II).

Note since there is no Medicare regulation that specifies what treatments are deemed 'palliative,' it is up to the individual hospice agency to determine whether or not they can financially and philosophically provide the interventions listed below. Most hospice agencies are not able to provide high-cost interventions due to financial limitations; patients may elect to be discharged from hospice care if they wish to pursue these options. Hospices with a large number of enrolled patients have greater financial resources and thus are better able to provide high-cost treatments. Recently, some hospices have introduced 'open-access' programs which more freely provide costly and even life-prolonging therapies to dying patients who would otherwise benefit from hospice services. The hope is that the increased costs will be covered by increased revenue from enrolling more patients earlier in the course of their illness.

Indications for use in Hospice Care In general, the interventions listed below are potentially indicated in patients with a) a good functional status (up, out of bed > 50% of the time; Karnofsky Performance Status >50; ECOG ≤2), or b) a clear goal to be met (e.g. wedding anniversary in two weeks). These interventions are not indicated solely to assist patients or families psychologically cope with impending death – to give the impression that 'something is being done.'

- **Parenteral Fluids** Indication: symptomatic dehydration where there is a patient-defined goal (e.g. upcoming family event). Fluids are not indicated to treat dry mouth or solely to reverse dehydration occurring as a normal aspect of the dying process; fluids may be of benefit to treat delirium in selected patients.
- **Enteral feeding** Indication: patient is hungry and there is a reason oral nutrition cannot be given (e.g. upper GI obstruction from esophageal cancer).
- **Total Parenteral Nutrition** Indication: patient has short-gut syndrome or bowel obstruction and good functional status and a functional goal.
- **Radiation Therapy** Indication: symptoms of pain, bleeding, or neurological catastrophe (e.g. acute spinal cord compression) and the patient is expected to live long enough to experience benefit (> 4 weeks) and the potential benefits outweigh logistic burdens (e.g. travel to the radiotherapy site, getting on and off the treatment table).



- **Red Blood Cell Transfusions or Erythropoietin** Indication: Symptomatic anemia (dyspnea or fatigue) in ambulatory patients who demonstrate continued functional benefit from treatment.
- **Platelet Transfusions** Indication: active bleeding and severe thrombocytopenia (Platelet count < 10,000).
- **Chemotherapy** Indication: symptoms from the cancer are causing distress; the likelihood of effectiveness is high (expected Response Rate greater than 25%); patient will live long enough to benefit (> 4-8 weeks, ECOG 0-2); and benefits outweigh burdens.
- **Antibiotics** Indication: oral antibiotics are appropriate to treat simple symptomatic infections (e.g. UTI). Parenteral antibiotics are not indicated unless there is an identified susceptible organism, there is a clear functional goal to be met, the likelihood of successful treatment is high, and the patient is expected to live long enough to achieve benefit.
- **Laboratory/Diagnostic services** Indication: to monitor aspects of POC (e.g. warfarin monitoring) or as part of a diagnostic evaluation for a new symptom for which the testing is likely to substantially alter patient management. Note: diagnosis of a new problem that does not relate to the terminal illness can be evaluated and treated by the patient's primary care provider under usual Medicare billing (e.g. acute myocardial infarction).

REFERENCES

- 1 **The Hospice Manual.** Centers for Medicare & Medicaid Services. Available at: http://www.cms.hhs.gov/manuals/downloads/pub_21.zip. Accessed November 1, 2007.
- 2 **Wright AA, Katz IT.** Letting go of the rope – aggressive treatment, hospice care, and open access. *NEJM.* 2007; 357:324-327.
- 3 **Marantz Henig R.** Will we ever arrive at the good death? *New York Times.* August 7, 2005. Available at: <http://www.nytimes.com/2005/08/07/magazine/07DYINGL.html>. Accessed November 2, 2007

Version History This Fast Fact was originally edited by David E Weissman MD. 2nd Edition was edited by Drew A Rosielle MD and published November 2007; 3rd Edition June 2015. Current version re-copy-edited April 2009; then again in June 2015.

Copyright All Fast Facts and Concepts are published under permission from PCNW and Creative Commons Attribution - NonCommercial 4.0 International Copyright (<http://creativecommons.org/licenses/by-nc/4.0/>).

Disclaimer Fast Facts and Concepts provide educational information for health care professionals. This information is not medical advice. Fast Facts are not continually updated, and new safety information may emerge after a Fast Fact is published. Health care providers should always exercise their own independent clinical judgment and consult other relevant and up-to-date experts and resources. Some Fast Facts cite the use of a product in a dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.