Eli's Hospice Insider

PAYMENT :3 Simple Strategies Help Ensure Your Hospice Pays for the Right Meds

Over-or under-covering meds can cost your hospice.

Figuring out which meds your hospice should cover can get tricky, which is why you need to know the ins and outs of an issue that's fast on the road to becoming a compliance hot spot.

"It's just a matter of time" before Medicare contractors target the issue, opines attorney **Mary Michal,** attorney with Reinhart Boerner Van Deuren in Madison, Wis. That's because hospices that don't pick up the tab for medications could push the expense onto Part D, which would cost the government a lot of money, she cautions.

Never fear: Following these key principles can help you navigate the gray areas for covering medications.

1. Take a close look at the medication's relationship to the patient's diagnoses. "Medicare requires that hospices pay for medication related to the terminal diagnosis and its related conditions," says **Joy Barry, RN, MEd, CLNC,** principal of Weatherbee Resources Inc. in Hyannis, Mass. Thus, if someone has a long-standing history of mental illness for which he's been receiving medications, then that may be viewed as unrelated to the terminal illness, says attorney **Meg Pekarske,** with Reinhart Boerner Van Deuren. "But if the person had a history of depression, which resurfaces when he is dying, that may be related to the terminal illness -- and thus, antidepressants would be included in the hospice coverage."

2. Determine the purpose of the medication. The medications provided by hospice are used palliatively to manage the patient's pain and symptoms.

And oncologists may inform patients that their chemotherapy is "palliative," says Barry. However, the hospice medical director determines whether the treatment is truly palliative, she points out.

Answer this key question: What is the goal for the patient still on chemotherapy? If it's intended to shrink the tumor and manage symptoms, then the chemotherapy is palliative -- "even if it is psychologically rather than physiologically palliative," says Barry. Yet "some oncologists may find it difficult to stop chemotherapy or may be averse to having a conversation with the patient about his limited prognosis and treatment options."

Resolution: Such cases may present an ethical challenge for the hospice to resolve, says Barry. "For example, the hospice physician may need to facilitate a conversation with the oncologist, patient, and/or family about the patient's prognosis, treatment options, and goals of care."

3. Weigh carefully whether to pay for the newest and most expensive medication on the block. The distinction between palliative and curative is getting more difficult to make for some exorbitantly expensive chemotherapies, cautions **Mary Lynn McPherson, PharmD, BCPS,** professor and vice chair in the Department of Pharmacy Practice and Science at the University of Maryland in Baltimore. "For example, a tyrokinase inhibitor for lung cancer appears to make terminally ill lung cancer patients feel a bit better," she says.

The way out: "It's appropriate," says Michal, for the hospice to have a formulary designating what it thinks is appropriate therapy "where it'd be unusual for a certain medication to be used outside the formulary." And when dealing with an outlier medication, you'd ask as part of individualized care planning: "Is this medication the only way to palliate pain and symptoms?"

If a less expensive treatment hasn't relieved the patient's pain and advancing symptoms, says Barry, "the hospice can

move up the ladder to a more aggressive treatment approach." "These are patient-by-patient and organization-by-organization decisions that should be facilitated by the hospice physician in consultation with the [interdisciplinary group] and the patient's attending physician, if there is one."