Scramble or Script: Responding to New Medicare Billing for Medications in Hospice

Jennifer Tjia, MD, MSCE,¹ Shaida Talebreza, MD,² Maija Reblin, PhD,³
Anna Beck, MD,⁴ and Lee Ellington, PhD³

Dear Editor:

Turmoil ensued in March 2014 with changes to the Center for Medicare and Medicaid Services (CMS) hospice medication billing guidance. The guidance required beneficiary-level prior authorization (PA) for all prescription medications not provided by hospice to determine whether these medications would be coverable under Medicare Part D.¹ Medication coverage for hospice beneficiaries would be considered an “unusual and exceptional circumstance.” Both hospice providers and the patients and families they served scrambled to adhere to PA requirements. Concerns were raised about barriers in accessing necessary medications and potential inappropriate costs to patients/families.

After three months of confusion, CMS revised guidance in consultation with hospice providers to relax PA requirements to include only four classes of drugs “identified as nearly always covered under the hospice benefit:” analgesics, antiemetics, laxatives, and antianxiety drugs.² While this latest change provides some reprieve from abruptly needing to decide whether to prescribe or discontinue chronic disease medications in hospice, problems remain that hinder clinical care, quality of life, and expenditures for families.

Hospice patients are prescribed many medications—a recent study showed nurses and families discuss four different medications on average (range 0–11) during a single home visit.³ It is often overwhelming for families to track refills, dosages, timing, and payment sources. Upon hospice enrollment, nurses initiate complex medication management and payment discussions, and counsel families and patients regarding medications for which the original prescribing indications may be unknown. As evidence emerges on benefits to stopping medications such as statins at the end of life,⁴ the importance of optimizing communication between hospice providers and families will continue to grow.

It is frequently difficult for families to understand that medications must be cut and why. Some medications hold psychological significance; patients are often told that certain medications should be taken “for the rest of your life.” While stopping some medications makes medical sense when facing

life-limiting illness, patient/family resistance is common. Medication discontinuation may signify “giving up” or going against the initial prescriber’s orders. Training scripts to ensure family-centered communication in medication discussions can be helpful.

Tools developed at one hospice include (1) decision trees to determine which medications palliate and manage the terminal and related conditions, which are unrelated to the terminal prognosis, and which are no longer necessary or potentially harmful; (2) phrases that can be used to help align medication decisions with families’ goals of care (e.g., “Can you share with me what you are hoping for with this medication?”); (3) phrases that can be used to align medication decisions with clinical evidence (e.g., “This pill is not medically advised because...”); and (4) communication strategies for ensuring patient understanding (e.g., teach back, repetition).^{5,6}

These tools can be used by health care providers to discuss medications prior to hospice referral. Relying on hospice providers to assume the brunt of responsibility for shifting medication prescribing from cure to comfort care unfairly tasks hospice providers, and affords inadequate time for families to make informed decisions. It is time to upstream conversations about medication discontinuation, thus allowing families to prepare prior to their transition to hospice.

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¹Department of Quantitative Health Sciences, University of Massachusetts Medical School, Worcester, Massachusetts.

²School of Medicine, ³College of Nursing, ⁴Huntsman Cancer Institute, University of Utah, Salt Lake City, Utah.

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Address correspondence to:

Lee Ellington, PhD

Huntsman Cancer Institute

College of Nursing

10 South 2000 East

University of Utah

Salt Lake City, UT 84112-5880

E-mail: lee.ellington@nurs.utah.edu