Section 4 | MEMBER REFERRAL AND PPC ELIGIBILITY GUIDELINES

Please note that these guidelines should not be used as criteria for referral for office-based or inpatient palliative medicine consultation. In addition, this document is meant to provide direction in thinking about the benefit that a patient might receive from home-based palliative care under SB 1004. It is not intended to be a strict guideline, and clinical judgment must be applied to each case.

Step 1:
Qualifying medical eligibility criteria for pediatric patients under 21 years of age is on page 5 of California’s All Plan Letter 18-020 (Palliative Care). It is important to note that pediatric patients do NOT have to meet the eligibility criteria for adults outlined in sections I.A. and I.B. beginning on page 3 of the APL.

The family and/or legal guardian must agree to the provision of pediatric palliative care, and there must be documentation that the patient has a life-threatening diagnosis. This can include but is not limited to:

1. Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
2. Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
3. Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
4. Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult to control symptoms).

Step 2:
There should be an indication that medical services are needed in the home setting. This might be indicated by:

1. Emergency department visits for medical issues that could have been prevented or that could have been treated with an outpatient office visit.
2. Hospitalizations that were not planned and might have been prevented by education on recognition of symptoms and early intervention to prevent progression or by better adherence to the medical plan of care.
3. Frequent missed medical appointments.
4. A caregiver who is having difficulty navigating the complex medical system and coordinating the care of the patient. This might be more common in patients who have multiple subspecialists.
5. A caregiver who is able to identify that having home-based palliative care prevents trips to the emergency department or hospital.
6. Significant dependence on medical technology such as a central line or respiratory support (CPAP, BiPAP, or, ventilator)
7. Social barriers that are present and preventing optimal medical care. These might include but are not limited to:
   a. Issues with transportation to visits
   b. Difficulty understanding complex care instructions. A language barrier is one potential source of this type of issue
   c. Significant caregiver stress
   d. Significant financial stress
**Step 3:**
The need for home-based services frequently increases as a patient’s medical condition becomes more severe and the patient has more symptoms. The need is also more likely for patients experiencing new symptoms or a decline in condition.

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<th>Diagnoses Frequently Associated with Significant Symptom Management Needs</th>
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| **Neoplasms** | • Stage 3 or 4  
  • Any neoplasm not responding to conventional protocol (at least one relapse)  
  • Central nervous system tumors |
| **Cardiac** | • Major cardiac malformations for which surgical repair is not an option or awaiting surgery or transplant  
  • Severe anomalies of aorta and/or pulmonary arteries  
  • Heart failure |
| **Pulmonary** | • Cystic Fibrosis with multiple hospitalizations or emergency department visits in the previous year  
  • Pulmonary hypertension  
  • Refractory pulmonary hypertension  
  • Pulmonary hemorrhage  
  • Chronic or severe respiratory failure |
| **Immune** | • AIDS with multiple hospitalizations or emergency department visits in the previous year  
  • Severe Combined Immunodeficiency Disorder  
  • Other severe immunodeficiencies |
| **Gastrointestinal** | • Chronic intestinal failure dependent on TPN or awaiting transplant  
  • Other severe gastrointestinal malformations  
  • Liver failure in cases in which transplant is not an option or awaiting transplant |
| **Renal** | • Renal failure in cases in which dialysis, transplant are not an option, or awaiting transplant |
| **Neurologic** | • Holoprosencephaly or other severe brain malformations requiring ventilatory or alimentary support with at least four hospitalizations or emergency department visits in the previous year  
  • CNS injury with severe comorbidities  
  • Severe cerebral palsy/hypoxic-ischemic encephalopathy (HIE) with recurrent infections or difficult-to-control symptoms  
  • Batten Disease  
  • Severe neurologic sequelae of infectious disease or trauma |
| **Metabolic** | • Severe and progressive metabolic disorders including but not limited to leukodystrophy, Tay-Sachs disease, and others with severe comorbidities  
  • Mucopolysaccharidoses that meets Level of Care criteria |
| **Neuromuscular** | • Muscular dystrophy requiring ventilatory assistance (at least nocturnal BiPAP)  
  • Spinal muscular atrophy, type I or II  
  • Other myopathy or neuropathy with severity that meets Level of Care criteria as defined by the State |
| **Other conditions that meet Level of Care criteria, including but not limited to:** | • Severe epidermolysis bullosa or severe osteogenesis imperfecta  
  • Post-organ transplant with complications  
  • Congenital infection with severe sequelae (e.g. CMV, HSV, toxoplasmosis) |