



Palliative Care Services
Recertification Tool

Member Information	
Member Name:	Member ID #:
Date of Birth:	Date of Enrollment:
Provider :	Current Recertification Date:
Provider Signature:	Next Recertification Date:

Guidelines

The Recertification form must be completed by MD, NP, or PA involved in the member’s care. The member’s recertification for BSC’s Palliative Care Program is required every six months upon admission to the program. The form should be submitted up to 15 days before the end of the six-month enrollment period or no later than 2 business days after the start of the next enrollment period. The form shall be sent to bscpalliativecare@blueshieldca.com for review.

Failure to comply with this requirement may result in corrective action, up to and including contract termination.

Please complete all sections below

Section 1:	Eligibility Criteria for All Members
<p>1.a. General Eligibility Criteria The member must meet all the general eligibility criteria.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Is likely to, or has started to, use the hospital or emergency department to manage the member’s advanced disease; this refers to unanticipated decompensation and does not include elective procedures. <input type="checkbox"/> Has an advanced illness, as defined in Section 1.b below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment. <input type="checkbox"/> Death within a year would not be unexpected based on clinical status. <input type="checkbox"/> Has received appropriate patient-desired medical therapy or is a member for whom patient-desired medical therapy is no longer effective. The member is NOT in reversible acute decomposition. <input type="checkbox"/> The member and, if applicable, the family/member-designated support person, agrees to: <ul style="list-style-type: none"> o Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and o Participate in Advance Care Planning discussions.
<p>1.b. Disease-Specific Eligibility Criteria: The member must meet at least one of the four disease-specific eligibility criteria.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Congestive heart failure (CHF): Must meet (a) AND (b) <ul style="list-style-type: none"> a. Meets criteria for the New York Heart Association’s (NYHA) heart failure classification III or higher. b. The member has an ejection fraction of less than 30 percent for systolic failure <u>OR</u> significant co-morbidities. <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD): Must meet (a) OR (b) <ul style="list-style-type: none"> a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted <u>AND</u> a 24-hour oxygen requirement of less than three liters per minute. b. The member has a 24-hour oxygen requirement of greater than or equal to three (3) liters per minute.

	<ul style="list-style-type: none"> <input type="checkbox"/> Advanced cancer: Must meet (a) <u>AND</u> (b) <ul style="list-style-type: none"> a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia. b. The member has a Karnofsky Performance Scale score less than or equal to 70 percent <u>OR</u> has failure of two lines of standard of care therapy (chemotherapy or radiation therapy). <input type="checkbox"/> Liver disease: Must meet (a) <u>AND</u> (b) combined or (c) alone <ul style="list-style-type: none"> a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, an international normalized ratio (INR) greater than 1.3. b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices. c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score of greater than 19. <input type="checkbox"/> Cerebral Vascular Accident/stroke: <ul style="list-style-type: none"> a. Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia. <input type="checkbox"/> Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD). <input type="checkbox"/> Severe Dementia or Alzheimer’s Disease. <input type="checkbox"/> Other (Fill in): _____
<p>2. Please provide a brief narrative</p>	<p>Please provide information that describes findings that support continued enrollment into the program; please include the following in the narrative, update on medical, psychosocial, spiritual needs; the member’s acuity; frequency of visits and how the member is still benefiting from the program.</p>

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Section 2	Brief Narrative