Children's Medical Services
California Children's Services
Provider Bulletin

DATE: **November 14, 2011**

SUBJECT: **"PARTNERS FOR CHILDREN" PEDIATRIC PALLIATIVE CARE PILOT PROJECT**

Please find the attached correspondence providing you with information related to Los Angeles County's "Partners for Children" Pediatric Palliative Care Pilot Project.

COUNTY OF LOS ANGELES
Public Health

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November 14, 2011

Dear CCS Providers,

Pediatric Palliative Care Pilot Program

We would like to acquaint you with an exciting new program, the Pediatric Palliative Care Pilot or "Partners for Children" (PFC). PFC offers hospice-like benefits to qualifying CCS children with life-limiting or life-threatening conditions. The goals are to improve quality of life, decrease suffering and maintain the family unit throughout the course of their illnesses, while decreasing the number of medical crises and avoiding unnecessary emergency room visits or hospitalizations.

PFC is the product of California Assembly Bill (AB) 1745, or the Nick Snow Act of 2006. The law directed the California Department of Health Care Services (DHCS), in partnership with Children Hospice and Palliative Care Coalition (CHPCC), to create a Pediatric Palliative Care Model in California. PFC is one of the Home and Community-based Service (HCBS) Medicaid Waivers, approved by the Federal Center for Medicare and Medicaid Services (CMS). Launched in late 2009, it is to enroll up to 1802 CCS children from 11 participating CCS counties over a 3-year period. Los Angeles County CCS joined PFC on October 31st, 2011.

PFC benefits include community-level care coordination, family education, in- and out-of-home respite, expressive therapies (art, music, child-life, and massage), pain and symptom management, and family counseling or bereavement. Compared to Standard Hospice which requires a physician-certified life expectancy of 6 months or less, PFC does not require any consideration of life expectancy. CCS children who enroll in PFC continue to receive all medically necessary treatment services for their CCS conditions.

Anyone can refer the child to PFC. The child's appropriate CCS-approved physician must sign a PFC referral form to complete the referral process. A designated CCS nurse case manager (CCS Nurse Liaison) will review the referral and ensure that the child meets all the PFC eligibility criteria. Once the criteria are met and the child/family is interested, the CCS Nurse Liaison would enroll the child. The child/family would then choose a DHCS-approved PFC provider, a hospice or a home health agency, who will be responsible for assessing palliative care goals and create the Family-Centered Action Plan (F-CAP). The PFC provider would execute PFC benefits according to the F-CAP.

For more details about PFC, please go to the following web link:
http://www.dhcs.ca.gov/services/ppc/Pages/default.aspx

Thank you very much for your care and support for our most vulnerable children and their families.

Sincerely,

Los Angeles County CCS

Attachments (5)

PFC SUMMARY SHEET

PFC Eligibility Criteria:

1. Age <21 year old.
2. Full Scope Medi-Cal (FSMC) no Share of Cost, not enrolled in other Home Community-based Service (HCBS) Waiver.
3. Reside in one of the 11 PFC participating counties (including Orange, and Los Angeles).
4. Has one of the PFC eligible CCS conditions.
5. Meet Level of Care (LOC) criteria.

LEVEL of CARE Criteria:

Anticipated to need at least 30 days **(cumulative)** of hospitalization in an acute care facility in the subsequent 12 month period if not enrolled in this waiver.

CCS PFC contacts:

Los Angeles:

May Randolph	CCS Nurse Liaison	626-569-3997
Cecille Ellorin	RN Supervisor, Back-up	626-569-3900
Sidney Sumethasorn	CCS physician	626-569-3969
FAX: 1-800-924-1154		

Orange:

Vicki Munzing	CCS Nurse Liaison	714-347-0415
Patricia Rico	CCS Nurse, Back-up	714-347-0425
Thanh-Tam Nguyen	CCS physician	714-347-0427

Conditions Eligible for Pediatric Palliative Care Waiver

Neoplasms ICD-9 Codes 140-208, 235-238, 239

- Neoplasm, Stage 3 or 4
- Any neoplasm not responding to conventional protocol (at least one relapse)
- Central nervous system tumors

Cardiac ICD-9 Codes 745, 746, 747.1, 747.2, 747.3, 747.4

- 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 ICD-9 Codes 428.0 - 428.99

Pulmonary

- Cystic Fibrosis with multiple hospitalizations or emergency department visits in the previous year ICD-9 Codes 277
- Pulmonary hypertension ICD-9 Codes 416.0 - 416.8
- Refractory pulmonary hypertension ICD-9 Code 416.0
- Pulmonary hemorrhage ICD-9 Codes 770.3, 786.31
- Chronic or severe respiratory failure ICD-9 Codes 518.81, 518.83, 518.84

Immune

- AIDS with multiple hospitalizations or emergency department visits in the previous year ICD-9 Code O42
- Severe Combined Immunodeficiency Disorder ICD-9 Code 279.2
- Other severe immunodeficiencies ICD-9 Codes 279

Gastrointestinal

- Chronic intestinal failure dependent on TPN ICD-9 Code 579.3
- Other severe gastrointestinal malformations ICD-9 Codes 751.1, 751.2, 751.3, 751.5
- Liver failure in cases in which transplant is not an option or awaiting transplant ICD-9 Codes 570, 572.8, 751.61

Renal

- Renal failure in cases in which dialysis or transplant are not an option, or awaiting transplant ICD-9 Codes 585.6, 586

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 ICD-9 Code 742.2
- CNS injury with severe comorbidities ICD-9 Codes 851 - 854, 952
- Severe cerebral palsy/HIE with recurrent infections or difficult-to-control symptoms ICD-9 Codes 343, 768.7

- Batten Disease ICD-9 Code 330.1
- Severe neurologic sequelae of infectious disease or trauma ICD-9 Codes 323.6, 331.4, 342, 344, 851 - 854, 952

Metabolic

- Severe and progressive metabolic disorders including but not limited to: leukodystrophy, Tay-Sachs disease, and others with severe comorbidities ICD-9 Codes 330.0, 330.1, 330.8
- Mucopolysaccharidoses that meets Level of Care criteria below ICD-9 Code 277.5

Neuromuscular

- Muscular dystrophy requiring ventilatory assistance (at least nocturnal BiPAP) ICD-9 Codes 359.0, 359.1
- Spinal muscular atrophy, Type I or II ICD-9 Codes 335.0 - 335.19
- Other myopathy or neuropathy with severity that meets Level of Care criteria below ICD-9 Codes 334, 335.2, 335.8, 335.9, 336

Other conditions that meet Level of Care criteria below, including but not limited to:

- Severe epidermolysis bullosa ICD-9 Code 757.39
- Severe osteogenesis imperfect ICD-9 Code 756.51
- Congenital infection with severe sequelae (e.g. CMV, HSV, toxoplasmosis) ICD-9 Codes 771.0, 771.1, 771.2
- Post-organ transplant with complications ICD-9 Code 996.8

Other non-listed conditions will be given ICD 9 code on case by case basis

PARTNERS FOR CHILDREN (PFC) Referral Form

Provider Information

1. Date of Request | 2. Provider Name

3. Address (Number, Street, Suite, Mail Stop)

City | State | ZIP Code

4. Contact Person | 5. Contact Phone Number ( ) | 6. Contact Fax Number ( )

Client Information

7. Client Name - Last | First | Middle

8. Gender ☐ Male ☐ Female | 9. Date of Birth | 10. CCS Case Number

11. Client Index Number (CIN)

County of Residence

12.

Waiver Eligible Diagnosis

13. a. Waiver Diagnosis	b. ICD-9	c. Special Criteria

Hospitalization

14. Do you anticipate that this child would need at least 30 days of hospitalization in an acute care facility this year if he/she were not enrolled in this waiver? ☐ Yes ☐ No

Medical Reports Attached

15. ☐ Yes - Attach reports documenting clinical findings, prognosis, treatment and recommendations related to waiver diagnosis to this document.

☐ No - Please explain

Reason(s) for Referral

16.

17. Provider Signature: _____

Civil Code Section 1798.17 provides that the individual will be notified of the intended purpose and use of personal information being collected. Information on this document will be used exclusively by the Department of Health Care Services and affiliates of the Partners for Children program for the purposes of monitoring and providing quality services to PFC participants.

INSTRUCTIONS

1. Date of the Request: Date the request is being made.

Provider Information

2. Provider's Name: Enter the name of the provider who is requesting services.
3. Address: Enter the requesting provider's address.
4. Contact Person: Enter the name of the person who can be contacted regarding the request.
5. Contact Phone Number: Enter the phone number of the contact person.
6. Contact Fax Number: Enter the fax number for the provider's office or contact person.

Client Information

7. Client Name: Enter the client's name—last, first, and middle.
8. Gender: Check the appropriate box.
9. Date of Birth: Enter the client's date of birth. (mm/dd/yyyy)
10. CCS Case Number: Enter the client's CCS number. If not known, leave blank.
11. Client Index Number (CIN): Enter the client's CIN number. If not known, leave blank.

County of Residence

12. Enter the county where the child resides. It must be one of the waiver participating counties.

Waiver Eligible Diagnosis

13. a. Waiver Diagnosis: Enter the waiver eligible diagnosis.

    b. ICD-9: Enter the ICD-9 Code, if known.

    c. Special Criteria: Enter the severity criteria specific to the diagnosis.

Hospitalization

14. Expected to require at least 30 days of hospitalization in the next year in the absence of PFC waiver services: Check Yes or No

Medical Reports Attached

15. Check Yes or No:

    If Yes, attach all medical reports that the CCS program **<u>does not</u>** have which are necessary to verify waiver eligible diagnosis.

    If No, explain why not [records already available at county CCS office, records requested: to be sent separately, etc.].

Reason(s) for Referral

16. Describe the reason for this client's referral to Partners for Children. Include social as well as medical needs/factors and anticipated benefits to the client, family and health care team as a result of waiver participation.

Signature

17. Signature of physician or provider: Form must be signed by the physician or authorized representative.