blue california
Promise Health Plan

Policy Title: Patients with Terminal Illness		**POLICY #**: 10.02.48	
		Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 4/10	**Effective Date** 11/22	**Revision Date** 9/24
Governing Committee: Medical Services Committee			
Governing Committee Approval: Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer			**Date:** 9/9/24
Vice President (VP) Approval: Tracy Alvarez, VP, Medical Care Solutions			**Date:** 9/9/24

A. PURPOSE

To establish and implement guidelines for identifying terminally ill patients and communicating utilization management (UM) decisions related to terminally ill patients, as set forth in Title 22, California Code of Regulations (CCR) §51349 and California Health and Safety Code (HSC) §§1368.1 & 1368.2.

B. DEFINITIONS

1. "Experimental services" - those drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans.

2. "Hospice" - Hospice care is a Medi-Cal benefit that serves terminally ill members. It consists of interventions that focus primarily on pain and symptom management rather than a cure or the prolongation of life. To qualify for hospice care, a Medi-Cal member must have a life expectancy of six months or less.

3. "Palliative" - Interventions that focus primarily on reduction or abatement of pain and other disease-related symptoms, rather than treatment aimed at

investigation and intervention for the purpose of cure or prolongation of life.

4. "Terminal Illness" - an incurable or irreversible condition that has a high probability of causing death within one year or less if the illness runs its normal course.

C. POLICY

I. The Blue Shield of California Promise Health Plan (Blue Shield Promise) Medical Services Committee (MSC) oversees the development and implementation of an effective referral/authorization process for members identified as terminally ill. This process and structure involve the Utilization Management (UM) Program's methods for reviewing and authorizing requested healthcare services. Responsibilities are assigned to the appropriate health care professionals; see UM P&P 10.2.56 Appropriate Professionals, UM Review and Support. The process is evaluated, updated and approved annually by the MSC.

II. The UM Staff work within their scope of practice and in conjunction with the Chief Medical Officer (CMO) or physician designee to process authorizations appropriately. The CMO has substantial involvement in the authorization review and approval process. Appropriately licensed health professionals will supervise all review decisions.

III. Pursuant to All Plan Letter (APL) 13-014, hospice services, as specified in 22 CCR §51349, are covered under the Blue Shield Promise contract and do not affect a member's eligibility for enrollment in Blue Shield Promise. HSC §1368.2 requires hospice care provided in California by licensed health care service plans to be at least equivalent to the hospice benefits provided under the Medicare program, as defined in the Social Security Act (SSA), Section 1861(d)(1) (42 United States Code 1395x).

IV. Blue Shield Promise will ensure that appropriate processes are used to identify, review and approve the provision of medically necessary covered services for members with terminal illness.

D. PROCEDURE

HOSPICE CARE

I. If, during the course of treatment, a member is certified by a physician as having a life expectancy of six months or less, they may elect to have hospice care.
   a. A hospice will obtain written certification of terminal illness for each hospice benefit period.
   b. The physician certification will contain the qualifying clause: "the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course."
   c. The member's election of hospice care services will include the following on an appropriate hospice election form:
      i. The identification of the hospice.

ii. The member's or representative's acknowledgement that:
    a) He or she has full understanding that the hospice care given as it relates to the individual's terminal illness will be palliative rather than curative in nature.
    b) Certain specified Medi-Cal benefits are waived by the election as specified in 22 CCR § 51349.
iii. The effective date of the election.
iv. The signature of the member or representative.

d. As stated in Section 1812(d)(1) of the SSA and 42 CFR § 418.21, an individual may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.

II. Routine, continuous or respite home hospice care does not require prior authorization. The only requirement for the initiation of outpatient hospice services is a physician's certification that a member has a terminal illness and the member's election of such services.

III. Inpatient hospice care requires medical necessity review for the stay.
- a. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings.
- b. Documents to be submitted for inpatient authorization include:
    i. Certification of physician orders for general inpatient care.
    ii. Justification for this level of care.
- c. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.
- d. To ensure timely access to hospice care services, Blue Shield Promise will communicate UM decisions to the provider within 24 hours of receipt of all medical necessity information.

IV. If inpatient hospice services are denied, Blue Shield Promise will provide a written response to the member within five (5) business days which includes the following:
- a. A statement setting forth the specific medical and scientific reasons for denying coverage.
- b. A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
- c. Copies of the plan's grievance procedures or complaint form, or both. The complaint form will provide an opportunity for the member to request a

conference as part of the plan's grievance system provided under HSC §1368.

V. Services not covered:

a. Private pay room and board or residential care.
b. Acute inpatient hospitalization unrelated to the terminal illness.
c. Level A or Level B nursing facility for unrelated issues.
d. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice.
e. Other necessary services for conditions unrelated to the terminal illness.

EXPERIMENTAL SERVICES

I. Decisions about "experimental" or "investigational" requests that are always excluded and never covered under any circumstances do not require medical necessity review. In these instances, Blue Shield Promise will either:
   a. Identify the specific service or procedure excluded from the benefits plan, or
   b. If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, ensure the materials state that members have the opportunity to request information on excluded services or procedures and Blue Shield Promise maintains internal policies or criteria for these services or procedures (2024 National Committee for Quality Assurance [NCQA] UM 10 standards).

   See: UM Policy 10.02.47 Experimental and Investigational Services.

II. If a Blue Shield Promise Medical Director denies coverage to a member with a terminal illness for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, Blue Shield Promise UM will provide to the member within five (5) business days all the following information:
   a. A statement setting forth the specific medical and scientific reasons for denying coverage.
   b. A description of alternative treatment, services, or supplies covered by the plan, if any.
   c. Copies of Blue Shield Promise's grievance procedures or complaint form, or both. The complaint form will provide an opportunity for the member to request a conference as part of the plan's grievance system provided under HSC §1368.

III. For additional information on the grievance process, see Member Appeals and Grievances P&P 10.19.5 Beneficiary Grievance Management System.

E. MONITORING

N/A

F. REPORTING

N/A

G. ATTACHMENTS

N/A

H. REFERENCES

1. 22 CCR §51349
2. 42 CFR §418.21
3. 42 USC §1395x
4. BSCPHP Medi-Cal Provider Manual, Appendix 13: UM Timeliness Standards
5. BSCPHP Member Handbook
6. DHCS Contract, Exhibit A, Attachment III, Section 5.3.7(B)
7. HSC §1339.31(b)
8. HSC §1368.1
9. HSC §1368
10. HSC §1368.2
11. NCQA UM 10
12. SSA §1861(dd) (42 USC §1395x)
13. APL 13-014: Hospice Services and Medi-Cal Managed Care
14. SSA § 1812(d)(1)
15. 10.02.47 Experimental and Investigational Services
16. 10.2.56 Appropriate Professionals, UM Review and Support
17. 10.19.5 Beneficiary Grievance Management System

I. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-filing Number
9/24	2024 Annual Review • Formatting/grammatical updates • Reviewed/updated references	
10/23	Annual review Updated verbiage and references to regulatory requirements, UM P&P	
	New Policy • Split from policy 10.2.48 Investigational Services	