blue california
Promise Health Plan

Policy Title: California Children's Services		POLICY #: 10.2.17 Line of business: Medi-Cal	
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Department Head: Mirela Albertsen, UM Senior Director		**Date: 9/23/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 9/27/21**	

PURPOSE

To ensure members less than 21 years of age with eligible medical conditions are referred to the California Children's Services (CCS) program for evaluation. Blue Shield of California Promise Health Plan (Blue Shield Promise) continues responsibility for a member's healthcare services if a member is not determined to be eligible for, or ages out of, the CCS program.

DEFINITIONS:

1. Case Management Services are those services intended to assist individuals eligible under the Medi-Cal State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.17 and 440.169. Refer to UM Policy 10.2.29 Case Management Coordination of Care

2. Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) services, means a benefit of the State's Medi-Cal program that provides comprehensive, preventative, diagnostic, and treatment services to eligible children under the age of 21, as specified in section 1905(r) of the Social Security Act. Refer to UM Policy 10.2.4 EPSDT.

3. Home Health Agency (HHA) as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.

4. Individual Nurse Provider (INP) means a Medi-Cal enrolled Licensed Vocational Nurse or Registered Nurse who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.

5. Private Duty Nursing means nursing services provided in a Medi-Cal beneficiary's home by a registered nurse or a licensed practical nurse, under the direction of a beneficiary's physician, to a Medi-Cal beneficiary who requires more individual and continuous care than is available from a visiting nurse. (42 CFR. § 440.80.)

6. CCS Paneled refers to hospitals and doctors that completed the County CCS application process and demonstrated the knowledge and experience to care for children with CCS-eligible conditions.

7. Age Out and Transition Process refers to a CCS eligible member transitioning to adulthood.

8. Hospice Care is a multidisciplinary approach to care that is designed to meet the unique needs of terminally ill individuals and their families. It is used to alleviate pain and suffering and treat symptoms rather than cure illness. Items and services are directed toward the physical, psychosocial, and spiritual needs of the patient/family. Medical and nursing services are designed to maximize the patient's comfort and independence.

9. Palliative Care includes interventions that focus primarily on reduction or abatement of pain and suffering or other problems, physical, psychosocial, spiritual, and other disease-related symptoms, by means of early identification, assessment and treatment rather than interventions aimed at investigation and/or interventions for the purpose of cure or prolongation of life.

10. Terminally ill means that that an individual's medical prognosis as certified by a physician, results in a life expectancy of 6 months or less. Health and Safety Code Section 1746 expands the definition to include a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course. Certification of terminal illness in compliance with 42 Federal Code of Regulations (CFR) 418.22(b) requires the physician certification contain the qualifying clause in relation to the described definition of terminally ill, "if the terminal illness runs its normal course.

11. Curative services are defined as those given with the goal of long-term cure or disease-free state of the child and are covered under Concurrent Care.

POLICY

CCS is a carved-out benefit of the Blue Shield Promise benefits agreement. The CCS program provides diagnostic and treatment services, medical case management, physical and occupational therapy, and Medical Therapy Program (MTP) services to children under the age of 21 with CCS eligible medical conditions.

Identified children with CCS eligible conditions are referred to County CCS Program upon identification.

1. Blue Shield Promise will ensure a process to include the following:
    a. Providers are responsible for performing appropriate baseline assessments and diagnostic evaluations that provide sufficient clinical detail to establish or raise a reasonable suspicion, that a member has a CCS eligible medical condition.
    b. Assure that contracted providers understand that CCS reimburses only CCS paneled providers, and only from the date of referral.
    c. Initial referrals of members with CCS eligible conditions can be made to the County CCS program by telephone, same-day fax or via the website. Followed by submission of supporting medical documentation, if available, to allow for eligibility determination by the County CCS program.
        i. Blue Shield Promise providers are responsible for providing all medically necessary covered services to the member until CCS eligibility is confirmed.
    d. Once eligibility for the CCS program is established for a member, Blue Shield Promise providers shall continue to provide all medically necessary covered services that are not authorized by CCS. Blue Shield Promise shall ensure the

exchange of medical record information, coordination of services and joint case management between the Primary Care Provider (PCP), the CCS specialty providers, and the County CCS program.

i. If the County CCS program does not approve eligibility, Blue Shield Promise remains responsible for the provision of all medically necessary covered services to the member.

1. Blue Shield Promise will refer ineligible members to other Medi-Cal programs and departments (i.e. Social Services, Complex Case Management, Children with Special Health Care Needs, Care Management and Behavioral Health) to ensure care coordination for the member's existing needs.

ii. If the County CCS program denies authorization of any service, Blue Shield Promise remains responsible for ensuring any medical needs listed in the member agreement is coordinated and paid for by Blue Shield Promise.

2. Blue Shield Promise or IPA/PPG Case Management shall assist in the coordination of care between the PCP, CCS Specialty Provider, and the County CCS program. All members who are referred to CCS or confirmed to have a CCS eligible condition shall be managed by Case Management.
3. The CCS program authorizes Medi-Cal payments to Blue Shield Promise in-network physicians who are CCS approved paneled providers, and to other providers who provided covered CCS services to the member during the CCS eligibility determination period. Blue Shield Promise shall submit information to the CCS program on all providers who have provided services to a member thought to have a CCS eligible condition.
4. Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by Blue Shield Promise or a network physician shall be allowed until the next working day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

Transition/Age Out:

1. CCS services ends when any of the following changes occur:
    a. Member no longer has a CCS eligible condition because the condition has changed, or treatment is complete
    b. Member is no longer financially eligible
    c. Member turns 21 years old (on the Members 21st birthday)
    d. Member no longer resides in the State of California
2. Transition:
    a. Blue Shield Promise will begin transition planning with the child's family when CCS services end for any of the above reasons.
    b. Blue Shield Promise Health Plan will assist the child's family, the treating CCS provider/Specialty Care center and the CCS case manager to begin planning for the child's health coverage, primary care physician, specialty care, medications, medical equipment, other supplies, living arrangements, legal decisions, recreational, social, educational, other activities, and other services.
    c. Blue Shield Promise will ensure the transition plan will also include communication with beneficiaries regarding, but not limited to, authorizations, provider network, case management, and ensuring continuity of care and services for beneficiaries in the process of transitioning from CCS.
        i. For CCS members aging out of the program, the CCS nurse will include the CCS County program in the development of the transition plan before submitting to DHCS for approval.

Private Duty Nursing (PDN)

1. When County CCS has approved a CCS participant who is an EPSDT eligible Medi-Cal beneficiary to receive PDN services for treatment of a CCS condition, the CCS program has primary responsibility to provide Case Management for approved PDN services.
2. Regardless of which Medi-Cal program entity has primary responsibility for providing Case Management for the approved PDN services, an EPSDT eligible Medi-Cal beneficiary approved to receive Medi-Cal PDN services, and/or their personal representative, may contact any Medi-Cal program entity that the beneficiary is enrolled in (which may be a MCP, CCS, or the Home and Community Based Alternatives Waiver Agency)to request Case Management for PDN services. The contacted Medi-Cal program entity must then provide Case Management services as described herein to the beneficiary and work collaboratively with the Medi-Cal program entity primarily responsible for Case Management.
3. Members may choose not to use all approved PDN service hours, and Blue Shield Promise is permitted to respect the member's choice. Blue Shield Promise must document when a member chooses not to use approved PDN services and all efforts to locate and collaborate with providers of PDN services including other entities such as CCS.

Hospice Care:

Blue Shield Promise will ensure that the member receives medically necessary care concurrently with hospice care.

1. Blue Shield Promise will ensure that hospice services will be made available to children without foregoing other Medi-Cal services for treatment of the terminal condition and that all medically necessary curative services must be available even if the member and their family elects hospice services, providing a blended package of curative and palliative services.
2. Services that are palliative or do not meet CCS medical necessity criteria shall be the responsibility of Hospice.

Palliative Care:

Blue Shield Promise will ensure that members who qualify for palliative care receive patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under Blue Shield Promise contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving Palliative Care.

1. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.
2. CCS clients with life-threatening conditions and a life expectancy that is longer than six months, certain palliative care services may be provided through CCS when the palliative care is part of the plan of care of a Special Care Center (SCC).
    a. Utilizing a multidisciplinary approach and family-centered care principles, the staff at the SCC perform an assessment and develop an integrated plan, combining curative or life-prolonging treatment with palliative care.
    b. Pediatric Palliative Care (PPC) services are provided in coordination with the patient, family, primary care physician, subspecialty, and other community-based providers that may provide PPC services, including Blue Shield Promise Health Plan
3. Palliative care services may be authorized by the County CCS Program if they are part of a plan of care of a CCS Special Care Center (SSC) as stipulated by N.L 12-1119

Major Organ Transplant (MOT):
Most pediatric conditions requiring organ transplants qualify as a CCS-eligible condition. As such MOTs for pediatric members are required to be performed only in a CCS-approved Special Care Center (SCC).

If the CCS program determines that the member is not eligible for the CCS program, but the MOT is medically necessary, the MCP will be responsible for authorizing the MOT.

Referrals of pediatric members to the County CCS program for CCS eligibility determination must occur within 72-hours of the member's PCP or specialist identifying the member as a potential candidate for MOT.

- The County CCS program will be responsible for referring the CCS-eligible member to the transplant SCC.
- An Integrated Systems of Care (ISCD) Medical Consultant or designee will be responsible for determination of medical necessity and adjudication of the request for the MOT upon the SCC's confirmation that the member is a suitable candidate for the MOT.

PROCEDURE

1. All authorizations request initially screened by the Utilization Management (UM) Coordinators for members age 21 and under. After screening and using UM Matrix to determine if member meets potential CCS Medical eligible condition, the UM Team will send a referral to the CCS team.
2. The CCS team will determine if the request for authorization is a potential CCS eligible medical condition. The Clinical Support Coordinators will verify the member's Medi-Cal eligibility.
    a. If not, the authorization referral will be handled as outlined in the policies and procedures of processing an authorization request.
    b. If the member's medical condition is suspected to be an open CCS case based on the nature of the condition, the Clinical Support Coordinator will contact the County CCS program and verify if the case is open/closed or never referred.
    c. If the case is currently open, the CCS nurse will prepare the denial letter to the provider, guardian, and the member's primary care physician stating the condition is a "carve out" CCS benefit and direct the requestor of the service to notify CCS through their specified authorization procedure.
    d. If the case is not established or current, the CCS nurse will direct the Clinical Support Coordinator to contact the member's PCP, to assist the PCP or the designated PCP's office staff member with an initial consultation to an appropriate CCS paneled provider for the condition.
3. If the PCP is CCS paneled provider and able to care for the specific condition, the provider will be asked to contact the County CCS program directly for authorization. The CCS nurse can assist the PCP in submitting Services Authorization Request (SAR) application to the County CCS program.
4. All CCS eligible members including initial CCS consultation referrals are documented into Case Trakker Dynamo (CTD) and Auth Accel.
    a. The CCS nurse contacts the member or the member's responsible party to assist coordinating the initial consultation appointment.
5. Once the consultation occurs, the Clinical Support Coordinator will request a copy of the consultation report and treatment plan from the specialist to determine if a referral will be sent to CCS for the condition.

6. When the treatment plan and consultation report are received, the information will be forwarded to the CCS nurse for review.
    a. If the information meets CCS medical eligibility criteria, an application requesting CCS benefits review will be referred to the County CCS program via the CCS website, for a case number.
7. The CCS nurse will send a copy of the member's CCS medical eligibility including SAR approval to the PCP to be entered as part of the member's medical record information.
8. All further requests for services that are received by Blue Shield Promise CCS department that are related to the member's CCS eligible condition will be referred and submitted to the County CCS program for SAR approval.
    a. If the case is denied by the County CCS program, Blue Shield Promise will ensure that the member continues to receive all medically necessary covered services and will be responsible for obtaining and paying for the service.
9. If the County CCS program does not approve eligibility, Blue Shield Promise remains responsible for the provision of all medically necessary covered services.
    a. The CCS nurse will review the County CCS program denial with a Blue Shield Promise Medical Director and assist in preparing the appeal to the County CCS Program for reconsideration, if warranted.
10. All in-patient hospital stays are reviewed by Blue Shield Promise UM Case Managers. If a potential CCS eligible medical condition is identified through this procedure, he/she will advise the hospital, if the facility is CCS paneled, to make a referral to the County CCS program and proceed with the above applicable steps to facilitate the process.
    a. If the hospital is not CCS paneled and the patient medical needs qualifies for inpatient care stipulated in the CCS eligible medical criteria, including current members currently enrolled in the CCS program, the Blue Shield Promise UM Case Manager will coordinate the transfer of the member to a CCS paneled hospital. If the member is not stable for transfer, the Blue Shield Promise UM Case Manager will inform the non-paneled hospital to contact the County CCS and request for SAR approval on all inpatient stay until the member is stable to transfer to a CCS paneled hospital.
    b. Upon determination that the hospitalized condition meets CCS eligibility, the Blue Shield Promise UM Case Manager will continue to follow the member until discharge. The CCS nurse will generate a letter that states the medical condition as a carved-out CCS benefit and will reach out to the member/family/caregiver to facilitate proper discharge planning and ensure appropriate care coordination once the member is discharge from the hospital.
11. All members determined to have a CCS eligible medical condition will be evaluated for Case Management needs.
12. For CCS members in need of PDN:
    a. UM Outpatient team will review requests for PDN and determine if it is medically necessary, approve number of hours, and authorize the request.
13. For members aging out, Blue Shield Promise will:
    a. Create a monthly report to identify members reaching 17 years of age.
    b. The CCS nurse will refer to the CCS program transition guidelines and will discuss with the member, member's family, PCP, and other health care disciplines to ensure a proper transition for the member from age 17 until the member turns 21.
    c. The CCS nurse will contact the member and the member's family at 60 days and again at 30 days prior to the member turning 21 to ensure a smooth transition.
    d. The CCS nurse will communicate via USPS mail, both a Transition Letter and Closure letter, to the member that his/her eligibility will end with CCS when he/she turns 21.

e. The CCS nurse will reach out to the member's PCP to assist in the facilitation of the member's transitional needs in finding an adult health coverage, PCP, specialty care, medications, medical equipment, other supplies, living arrangements, legal decisions, recreational, social, educational, other activities, and other services for the member.
f. If necessary, the CCS nurse may refer the member to Blue Shield Promise's Social Services, Complex Case Management, and Behavioral Health department to assist the member and the member's family with care coordination.

14. For members discharging from CCS services, the CCS nurse will:
    a. Refer to the CCS program transition guidelines and discuss with the member, member's family, primary care physicians, and other health care disciplines to ensure the safe transition occurs and necessary authorizations to access needed care are in place.
    b. The CCS nurse will call the member and the member's family between 30 and 60 days following the transition to ensure follow up care is occurring, assist with facilitation of the member's transitional needs in finding an adult health coverage, primary care physician, specialty care, medications, medical equipment, other supplies, living arrangements, legal decisions, recreational , social, educational, other activities, and other services for the member.
        i. If necessary, the CCS Nurse may refer the member to Blue Shield Promise Health Plan's Social Services, Complex Case Management, and Behavioral Health department to assist the member and member's family for care coordination.
    c. The CCS nurse will send the Transition Closure Letter after the final outreach call.
15. For CCS members eligible for palliative/hospice services a CCS nurse will:
    a. Issue authorization for palliative care services for all members meeting the palliative care eligible medical conditions criteria
    b. Reach out to the member, member's family, PCP, and explain that the CCS program eligibility of the member will continue during the member's enrollment in palliative/hospice services for a CCS eligible medical condition.
    c. Reach out to the County CCS program all authorizations request for continuing medically necessary services intended to treat the CCS eligible condition and maintain the status of the member except for palliative services, including pain control.
    d. Ensure coordination of care between Blue Shield Promise Health Plan and the palliative/hospice care providers and allow for the palliative/hospice interdisciplinary team to professionally manage the care of the patient as outlined in the law.
    e. Document all communication between the member, member's representative, primary care physician, County CCS program, and other member of the interdisciplinary team in Care Trakker Dynamo (CTD)
    f. Blue Shield Promise will facilitate hospice counseling service for grief, bereavement, and spiritual when needed.

Monitoring and Reporting:

1. Early Identification
    a. The CCS team will create a monthly report to identify all potential CCS eligible members through the following methods:
        i. The CCS team will create a monthly report from Auth Accel and Case Trakker Dynamo to identify all potential CCS eligible members with Flag indicators. The CCS team will create a monthly report from DHCS PEDI

report to capture all SAR approvals. The report will be compared to Blue Shield Promise's membership to identify all CCS eligible members, by reviewing DHCS International Classification of Diseases (ICD) codes assigned on admission with CCS eligible medical conditions.

b. The CCS nurse will notify the network providers responsible for the care of the identified CCS eligible member and inform them of the member's potential CCS eligible condition and request their evaluation of the case and make the necessary referrals as needed.
c. For newly identified CCS cases, the PCP will be notified that their patient is enrolled in the CCS program along with a reminder to continue providing the required primary care responsibilities, preventive services as well as anticipatory guidance to the children's parents or guardians.
d. The Blue Shield Promise CCS team utilizes Care Trakker Dynamo for all CCS program documentation.

Tracking and Monitoring:

1. The CCS team receives a monthly PEDI report from LA Care Health Plan will access a monthly report from the San Diego County CCS website (PEDI) for a list of approved members residing in San Diego County. The reports will be merged to develop a tracking report to share with the PCPs and assigned IPAs.
2. The CCS team will utilize the reports to develop a tracking report by adding the direct PCPs and delegated assigned IPAs. On a monthly basis, the report is sent to the IPAs with a reminder these members are on a service with CCS for an eligible condition and the continued responsibility to provide preventive health services as well as the provision of all medically necessary services not provided under the CCS service authorization.
3. All identified Blue Shield Promise CCS eligible member reports will be shared with Blue Shield Promise Delegation Oversight and with the appropriate IPAs.
4. Trends are reported quarterly through the UM leadership and Chief Medical Officer

Records and Maintenance:
The CCS team will maintain records of all potential CCS eligible members for no less than 10 years.

Provider Communication:
Blue Shield Promise's Provider Education and Relations team will ensure effective communication and partnership with the providers. The communication with the providers will include the following: provider manual, provider newsletter, faxes and via electronic mail.

To support reporting accuracy, Blue Shield Promise will educate network providers, hospitals, and physicians about the CCS program.

Delegation Oversight:
Blue Shield Promise adheres to applicable contractual and regulatory requirements and accreditation standards. All delegated entities with delegated UM responsibilities will also need to comply with the same standards. Refer to 70.24.91

Annual Policy Review and Updates:
Blue Shield Promise CCS Department will review this policy and all related desk level procedures annually or as needed to ensure adherence to all updates, revisions, and changes announced by DHCS regarding the CCS program.

REFERENCES

APL 18-020 Palliative Care
APL 20-012 Private Duty Nursing
Welfare & Institutions Code Section 14094
Health & Safety Code Section 123800
Title 22 Division 2 Subdivision 7: California Children's Services
DHCS All Plan Letter 12-014 Hospice Services and Medi-Cal Managed Care
PPACA, Section 2302 Law "Concurrent Care for Child"
LACDPH CCS Family Handbook