

PALLIATIVE CARE MEMBER REFERRAL FORM

Information about patient

Name: _____ DOB: _____ Age: _____

Home address: _____

Phone #: _____ Alternate Phone #: _____

HPSM member ID #: _____

Line of business: _____

Information about referring party

Agency/Organization/Facility: _____

Completed by: _____ Contact: _____

Referral Source: _____

Consent for referral obtained from: Patient AOR (consent must be obtained prior to submitting referral)

Does the patient have decision-making capacity?

Yes No (please provide information below)

If no, name of agent for decision-making: _____

If an AOR is on file, please identify: _____

4. PCP information

Name: _____

Phone #: _____ Contact person: _____

If patient sees a physician other than the assigned PCP for primary care, please enter the physician's name: _____

PALLIATIVE CARE MEMBER REFERRAL FORM

Member ID _____ Member Name _____ DOB _____

PALLIATIVE CARE ELIGIBILITY CRITERIA (Check all that apply)

Must meet ALL of Criteria A & ONE of Criteria B

A. General Eligibility Criteria (Must meet ALL)

The beneficiary is likely to, or has started to, use the hospital or emergency department as a means to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.

The beneficiary's death within a year would not be unexpected based on clinical status.

The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective. Patient is not in reversible acute decompensation.

The beneficiary and, if applicable, the family/patient-designated support person, agrees to:

- a. Attempt, as medically/clinically appropriate, in-home, residential-based or outpatient disease management/ palliative care instead of first going to the emergency room; AND
- b. Participate in Advance Care Planning discussions.

B. Disease Specific Eligibility Criteria (Must meet ONE)

Congestive Heart Failure (CHF): must meet (a) & (b)

- a. The beneficiary is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher; AND
- b. The beneficiary has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

Obstructive Pulmonary Disease (COPD): must meet (a) OR (b)

- a. The beneficiary has a Forced Expiratory Volume (FEV) 1 less than 35 percent or predicted and a 24-hour oxygen requirement of less three liters per minute; OR
- b. The beneficiary has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

Advanced Cancer: must meet (a) & (b)

- a. The beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia; AND
- b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 708 or has a failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

Liver Disease: must meet (a) & (b) combined, OR (c)

- a. The beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, AND
- b. The beneficiary has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; OR
- c. The beneficiary has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.