Non-Covered Benefit
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Non-Covered Benefit		
MNG #: 100	**☒ SCO ☒ One Care** **☒ MA Medicare Premier** **☒ MA Medicare Value** **☒ RI Medicare Preferred** **☒ RI Medicare Value** **☒ RI Medicare Maximum**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational: ☒**	**Informational: ☒**
Benefit Type: **☐ Medicare** **☐ Medicaid**	**Approval Date:** 2/3/2022	**Effective Date:** 05/07/2022;
Last Revised Date: 5/6/2022;	**Next Annual Review Date:** 2/3/2023; 5/6/2023;	**Retire Date:**

OVERVIEW:

A non-covered benefit is a resource that is not covered by Medicare or Medicaid that CCA care teams may consider medically necessary. These are, normally, rare exceptions to the yearly CCA benefit plan for a specific member based on their unique health needs, clinical context or "story." Such exceptions can be shown or reasonably anticipated to show a clear clinical value to the individual member and to CCA's overall programming for all members.

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

Clinical Eligibility:

A member may be eligible for a non-covered benefit, which may be called a "benefit exception," when CCA is provided a clear determination of need and rationale for how this resource will improve a member's individualized care plan. A member may receive a specified resource after a careful evaluation, individualized risk assessment, and well documented rationale showing how the benefit may be both reasonable (1) and medically beneficial (2).

(1) Reasonable-- Of modest or moderate cost outweighed by other cost savings or benefits
(2) Medically beneficial—Of reasonable likelihood to significantly improve a member's health and quality of life

Determination of need:

CCA will review prior authorization non-covered benefit requests as outlined in CCA MNG 045 Medical Necessity. In order to provide sufficient information to evaluate for medical necessity, the following documentation is required:

1. Individual Care Plan Documentation outlining the specific need that is being met.

2. Rationale for resource requested including necessary background information.
3. Documented evidence that the resource has clinical value for the identified need.
4. Clinical documentation that alternative approaches have been trialed and results of trials.
5. Clinical documentation (if relevant) as to why ordinary alternatives are less effective.
6. Individualized risk assessment shows what the risk may be of not providing this benefit to the member.
7. Anticipated outcome.
8. How anticipated outcome will be measured and evaluated.

Examples (this list is NOT all inclusive):

- Emergency Service Animal Pet Care– when a member is hospitalized if and only if all volunteer pet aid societies, ASPCA and senior center volunteers have already first been contacted for free volunteer assistance
- Craniosacral therapy (practitioners are not licensed per se) – when the practitioner has a massage license

LIMITATIONS/EXCLUSIONS:

A member is not eligible for a non-covered benefit if any of the following apply:

1. It is not considered to be medically necessary.
2. The anticipated outcome can be achieved through an alternate covered benefit.
3. If a network provider cannot provide the non-covered benefit and CCA is unable to develop a letter of agreement (LOA) with a provider for the benefit.
4. There is a co-morbidity for which the resource is contraindicated
5. Resource identified is experimental and investigational as outlined in CCA MNG 010 Experimental and Investigational Services.
6. Services reimbursable under automobile, no fault, any liability insurance, or workers' compensation
7. Paid for by another governmental entity and not covered under the Medicare and/or Medicaid benefits

Not Covered (this list is NOT all inclusive):

- Motel/Hotel rooms for shelter – While shelter contributes to health, this is not a covered service
- Sexual masturbation aids for paraplegia/quadriplegia – These are low cost and remain out of pocket expenses.
- Gym memberships – A gym can be reasonably achieved with home items and a home exercise program. Select CCA Plans may cover gym memberships under a separate fitness/wellness benefit. Members should refer to their individual product Evidence of Coverage or Member Handbook.
- Pool memberships – Would be recommended at the nearest YMCA, school, public or other community center. Select CCA Plans may cover memberships under a separate fitness/wellness benefit. Members should refer to their individual product Evidence of Coverage or Member Handbook.
- Organic food vouchers – organic food has not been shown to produce improved health outcomes. Under certain CCA Plans, members may be eligible to use their Healthy Savings card on approved food items. Members should

refer to their individual product Evidence of Coverage or Member Handbook.

Out-of-network or out-of-state exceptions for consultations with an herbalist, lyme 'expert', etc. – members must use in network clinicians whenever possible as many alternative treatments remain experimental

KEY CARE PLANNING CONSIDERATIONS:

CCA reviews all requests, including non-covered benefit items, on a case-by-case base and patient centered basis and individualized care plan. The purpose of this MNG is to provide a framework for how uncovered requests will be reviewed in conjunction with other applicable guidelines/criteria.

For **SCO and One Care** Members Our CCA care partner and care team must carefully evaluate alternative approaches to meeting the health goals of our members. They must thoroughly evaluate whether these goals can be achieved through covered benefits. The review and evaluation of medical necessities will be performed through the Authorization Department. All requests with accompanying documentation must be submitted in an Authorization Request and assigned to the Service Request Intake Team according to current CCA Standard Operating Procedure (SOP).

For all **MAPD and DSNP** members the requesting provider must determine if there is a covered benefit alternative. For non-covered benefit request must be submitted to the Authorization and Utilization Management Department for medical necessity review and organization determination. If the request does not meet medical criteria, it is then escalated to a Physician Reviewer, who uses applicable guidelines to make the final determination of whether the requested service is to be authorized.

Medical and hospital services arising from non-covered services are covered when determined to be reasonable and necessary.

- When a member is admitted to the hospital for a non-covered service:
  - ❖ Complications of non-covered procedures develop after the member has been formally discharged from the hospital providing the non-covered service. Example: A member undergoes a non-covered cosmetic procedure and, following discharge, develops an infection at the surgical site. Services to treat the infection are covered. This includes subsequent inpatient stays or outpatient treatment ordinarily covered under the member's health plan.
  - ❖ A complication develops that did not arise from a non-covered service or was not related to the non-covered service received by the member. Example: A member hospitalized for non-covered service breaks a leg while in the hospital. Services in connection with the broken leg are covered.
- When a member is admitted to the hospital for a covered service and obtains a non-covered procedure unrelated to the admission diagnosis, the services related to the admitting diagnosis would continue to be covered.

- Medical and hospital services arising from non-covered services that are related to the non-covered service are not covered. When a member is admitted to the hospital for a non-covered service: o
  - ❖ Complications that arise from, or are related to, a non-covered service before the member is formally discharged from the hospital providing that service

- ❖ A covered service which is in preparation for a non-covered service
- ❖ A covered service that is part of a treatment regimen for a non-covered service that requires a series of postoperative visits to a surgeon

- When a member is admitted to the hospital for a covered service and obtains a non-covered service during the same hospital stay, the non-covered service will not be covered. If, on the basis of the services and a comparison of the date, they are received with the date on which the member is identified as a candidate for a non-covered service, the services reasonably attributed to preparation for the non-covered service will not be covered.

AUTHORIZATION:

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

All requests with accompanying documentation must be submitted with the Authorization Request. If the benefit is deemed to be medically necessary under this MNG and CCA does not have an existing contract with a provider that can supply this benefit under the current contract, then a letter of agreement (LOA) must also be requested via the Clinical Effectiveness Unit.

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

Not covered by MassHealth or Medicare

RELATED REFERENCES:

Disclaimer

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another

service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

High Opioid Extreme Users (HOPE) members are patients with chronic pain and a care plan to limit opiate pain therapy to safer lowered doses. HOPE members may benefit from and are eligible for these MNG- guided services even when they do not meet all criteria. Clinicians requesting these services or an extension of these services for HOPE members please do the following:

1) Read the SOP's Approach to Chronic Pain SOP 090 & Pain Management in HOPE Members SOP 091
2) Consider your members' causes of discomfort and functional goals
3) Imagine how a different application of this service and/or more of this service may help them achieve higher function
4) Write this explanation for your request for central authorization of unusual or additional services beyond what this MNG normally recommends
5) Document a PROMIS-29 measure of our members' level of function and comfort
6) All HOPE variations to this standard MNG-driven care need to be reviewed quarterly (every 3 months)
7) Quarterly reviews must show member engagement/compliance with HOPE guidelines including both **BH and **Complementary/Alternative therapy
8) Quarterly reviews must show increased function and member satisfaction with a new PROMIS-29 evaluation in order to consider a further extension of HOPE-related services
9) CCA's goal remains to improve members' safe and successful function without opiate pain medication. When this happens then HOPE-related service extensions may be tapered and discontinued as tolerated

ATTACHMENTS:

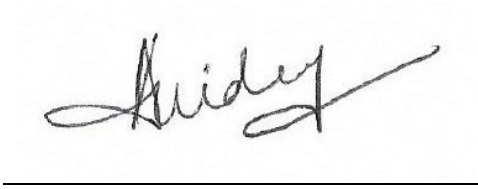
EXHIBIT A:	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION
5/6/2022	Template update

Non-Covered Benefit
Medical Necessity Guideline

APPROVALS:

Avideep Chawal	Director, Utilization Management
CCA Senior Clinical Lead [Print]	**Title [Print]**
	2/3/2022
Signature	**Date**
Click here to enter text.	
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Lori Tishler	Senior Vice President, Medical Services
CCA CMO or Designee [Print]	**Title [Print]**
	2/3/2022
Signature	**Date**