Decision Support Tool

Decision Support Tool (DST) Title: Non-Covered Benefit		
DST #: 134	**☒SCO ☒One Care**	**Prior Authorization Needed?** **☒Yes ☐No**
Clinical: ☒	**Operational: ☒**	**Informational: ☒**
Medicare Benefit: **☐Yes ☒No**	**Approval Date:** 2/1/2018;	**Last Annual Review Date:** 2/1/2018; 10/5/2018;
Last Revised Date: 2/1/2018; 10/5/2018;	**Next Annual Review Date:** 10/50/2019;	**Retire Date:**

OVERVIEW:

A non-covered benefit is a resource that is not covered by Medicare or MassHealth which 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 Eligibility:

A member may be eligible for a non-covered benefit which may be called a "benefit exception" when we are given 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 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:

In order to provide sufficient information to deem the benefit medically necessary, the following information is needed:

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

Examples (this list is NOT all inclusive):

- Air conditioners – cooler drier air reduces COPD and asthma exacerbations in summer weather

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- 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
- More frequent acupuncture, massage, or chiropractic therapy – when a member reflects our HOPE guidelines or otherwise shows reduced emergency room admissions, reduced hospital admissions, and improved functional goals

LIMITATIONS/EXCLUSIONS:

A member is not eligible for a non-covered benefit if:

1. It is not considered to be medically necessary or effective
2. The anticipated outcome can be achieved through alternate covered benefit means
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. The patient has a co-morbidity for which the resource is contraindicated
5. Resource identified is experimental in nature and a beneficial outcome is unlikely

Not Covered (this list is NOT all inclusive):

- Motel rooms for shelter – while shelter contributes to health, it 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
- Pool memberships – would be recommended at the nearest YMCA, school, public or other community center
- Organic food vouchers – organic food has not been shown to produce improved health outcomes
- 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
- Cellular PERS for wheelchair bound individuals in public places – the public in public places are expected to come to the aid of an individual in need as much as a family is expected to in a family's home

KEY CARE PLANNING CONSIDERATIONS:

A cost to benefit analysis is at the core of a non-covered benefit exception. This DST cannot become a DST supporting the use of 'anything & everything'. CCA recognizes that rigid top-down restrictions by Medicare and MassHealth are not always medically appropriate nor in the best interests of our members, CCA, or these our regulatory bodies. This DST preserves for our front line clinicians the flexibility and clinical agility which has made our programming a success. At the same time we must recognize that any diversion from conventional practice must be clearly bounded and carefully

justified in order to give our legal and clinical operations departments the ability to contain and maintain our clinical standards of care which are so important to fair, just, and equitable care for all of our members.

Our CCA care partner and care team must carefully evaluate alternative approaches to meeting the health goals of our members. They must carefully and completely evaluate whether these goals can be achieved through covered benefits without excessive and unreasonable cost. The review and evaluation of medical necessity will be performed through the Clinical Effectiveness Unit (CEU). All requests with accompanying documentation must be submitted in an outgoing referral to the Central Service Authorization team according to current CCA Standard Operating Procedure (SOP).

AUTHORIZATION:

All requests with accompanying documentation must be submitted in an outgoing referral to the Central Service Authorization team. If the benefit is deemed to be medically necessary under this DST 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:

Not covered by MassHealth or Medicare

RELATED REFERENCES:

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 DST- 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 member's 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 DST normally recommends
5) Document a PROMIS-29 measure of our members' level of function and comfort
6) All HOPE variations to this standard DST-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

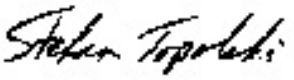
ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION

APPROVALS:

Stefan Topolski, MD	Associate Medical Director of Clinical Value and Quality
CCA Senior Clinical Lead [Print]	**Title [Print]**
	2/1/2018
Signature	**Date**
Click here to enter text.	
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Lori Tishler, MD	Vice President of Medical Affairs
CCA CMO or Designee [Print]	**Title [Print]**
	2/1/2018
Signature	**Date**