Non-Covered Benefit
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Non-Covered Benefit		
MNG #: 100	**☒ CCA Senior Care Options (HMO D-SNP) (MA)** **☒ CCA One Care (Medicare-Medicaid) (MA)**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Benefit Type: **☐ Medicare** **☐ Medicaid**	**Approval Date:** 2/3/2022	**Effective Date:** 05/07/2022; 12/29/2025
Last Revised Date: 5/6/2022; 11/9/2023; 12/29/2025	**Next Annual Review Date:** 2/3/2023; 5/6/2023; 11/9/2024; 12/29/2026	**Retire Date:**

OVERVIEW:

A non-covered benefit is a service/resource that is not covered by Medicare and/or Medicaid. In rare exceptions to Commonwealth Care Alliance (CCA) yearly benefit plan, CCA care teams may consider a non-covered benefit medically necessary for a specific member based on their unique health needs, clinical context or "story." Such exceptions must demonstrate or be reasonably anticipated to demonstrate a clear clinical value to the individual member and to CCA's overall programming for all members.

DECISION GUIDELINES:

A member may be eligible for coverage of a non-covered benefit, which may be called a "benefit exception," when CCA is provided with a documentation of medical necessity, which includes clear determination of need and rationale by the member's care provider, ordering clinician or care team member, for how this service/resource will improve a member's individualized care plan. A member may receive a specified service/resource after a medical necessity review is completed, which includes an 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

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Clinical Coverage Criteria:

Commonwealth Care Alliance will review prior authorization non-covered benefit requests as outlined in CCA Medical Necessity MNG. CCA may cover requested non-covered benefit when all the following criteria are met:

1. Member's Individual Care Plan Documentation outlines the specific need that would be met by the non-covered benefit and documentation supports the following:
   a. Rationale for resource requested including necessary background information; and
   b. Documented evidence that the resource is reasonable and medically necessary for the identified need; and
   c. Clinical documentation that alternative and covered approach(es) have been trialed and result(s) of trial(s); and
   d. Clinical documentation (if relevant) as to why ordinary alternatives are less or ineffective; and
   e. Individualized risk assessment demonstrating the risk of not providing this benefit to the member; and
   f. Anticipated outcome; and
   g. 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, American Society for the Prevention of Cruelty to Animals® (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 determined 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 an indication or co-morbidity for which the resource is contraindicated
5. Resource identified is considered experimental and investigational as outlined in CCA Experimental and Investigational Services MNG.
6. Services are reimbursable under automobile, no fault, any liability insurance, or workers' compensation
7. Services are 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.

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- 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 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 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 Member Handbook.
- Out-of-network or out-of-state exceptions for consultations with an herbalist, Lyme disease 'expert', etc. Members must use in network clinicians whenever possible as many alternative treatments remain experimental.
- Each member's or Member Handbook includes a list of non-covered benefits (exclusions). This list includes things such as:
    - Cosmetic surgery, unless it is needed because of an accidental injury or to improve a part of the body that is malformed or the functioning of a malformed body member. The plan will pay for reconstruction of a breast after a mastectomy.
    - Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan.
    - Radial keratotomy, LASIK surgery, and other low-vision aids.
    - This is not an exhaustive list and is meant to provide an idea of non-covered services. Members should refer to their individual product Member Handbook.

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, CCA care partner and care team must carefully evaluate alternative approaches to meeting the health goals of each member. They must thoroughly evaluate whether these goals can be achieved through covered benefits. The review and evaluation of medical necessity 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).

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

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- 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.

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.

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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

Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, 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.
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.

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. 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).

This Medical Necessity Guideline is not a rigid rule. As with all 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.

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REVISION LOG:

REVISION DATE	DESCRIPTION
12/29/25	Updated Evidence of Coverage to Member Handbook. Grammatical and formatting changes.
5/6/22	Template update
11/9/23	Additional examples of non-covered services per Member Handbook added to list
12/31/23	Utilization Management Committee approval
3/31/25	Template update. CCA products updated.

APPROVALS:

Jeffrey Sedlack	Senior Medical Director Utilization Review and Medical Policy
CCA Clinical Lead	**Title**
	12/29/2025
Signature	**Date**
CCA Senior Operational Lead	**Title**
Signature	**Date**
CCA CMO or Designee	**Title**