Policy Title:	Benefit Exception Inquiry (BEI) Request
Department:	Markets Growth & Retention
Business Unit:	Medicaid and Special Needs Plan
Approved By:	Director, Medicaid and SNP Product & Strategy
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PRODUCTS AFFECTED:

- Minnesota Senior Health Options (MSHO) – Medica DUAL Solution®
- Minnesota Senior Care Plus (MSC+) – Medica Choice Care^{SM} MSC+
- Special Needs BasicCare (SNBC) – Medica AccessAbility Solution®
- Special Needs BasicCare (SNBC) Integrated – Medica AccessAbility Solution Enhanced

DEFINITIONS:

Benefit Exception Inquiry: A formal written request completed by the member’s assigned Care Coordinator or Care Coordination entity to request a service or item outside of the standard benefit set covered by the product, or request to exceed Department of Human Services (DHS) case mix cap for MSHO/MSC+ Elderly Waiver (EW) members. Medica allows flexibility in benefits provided for Special Needs Products.

Care Coordinator (CC): A person who assesses the member, creates a person-centered care plan/support plan, and then coordinates the provision of services and supports for those members among different health and social services professionals and across settings of care.

Clinical BEI Review Team: An interdisciplinary team at Medica which includes but is not limited to the following license types: Registered Nurse, Social Worker, Public Health Nurse.

Denial Termination Reduction (DTR): 1) the denial or limited authorization of a requested service, including decisions based on the type or level of service; requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of Medica to act within the timeframes regarding the standard resolution of grievances and appeals; 6) denial of a member’s

request to dispute a financial liability, including cost sharing, or 7) for a resident of a Rural Area with only Medica, the denial of a member's request to exercise his or her right to obtain services outside the network. Action means the same as "adverse benefit determination" in 42 CFR § 438.400(b).

PURPOSE:
To ensure all Medica member BEI's are completed appropriately and in a timely manner using the applicable process and notification in accordance Medica requirements.

POLICY:
Counties, Agencies, and Care Systems that provide services for Medica members must complete BEI process in accordance with Medica requirements.

PROCEDURE:

1. Care Coordinator will receive request from the member for a service or item that is not a covered benefit or exceeds the member's benefit set. The Care Coordinator will verify coverage benefit by utilizing resources such as Minnesota Health Care Programs (MHCP) Manual, Community Based Services Manual (CBSM), Medica Customer Service, Medicare.gov, county/tribal waiver case manager, etc.

2. If per the assessment and professional judgement of the CC the service or item is not a covered benefit or exceeds the member's benefit set but the CC has determined it is an assessed need and/or affects member's health and safety, the CC may proceed with a BEI request.
    a. Prior to a BEI request, the CC will consider:
        i. Is this service/item necessary for the health, welfare, and safety of member?
        ii. Does this service/item enable the member to function with greater independence?
        iii. Is this service/item of direct and specific benefit to the member.
        iv. Is it the most cost-effective solution?
        v. Are there other formal or informal services that can meet the identified need?

Note: A BEI does not need to be submitted to obtain a denial of coverage. The CC can proceed directly to a DTR if CC determines it is not an appropriate request.

3. The CC completes the BEI Form referencing the BEI Form Instructions document obtained from the Medica Care Coordination Hub located under "tools and forms". If the BEI is determined by the Care Coordinator to be **URGENT**, the process will be completed as soon as possible. An URGENT request can be submitted when they relate to immediate health and safety concerns of the member. URGENT must be indicated on the BEI Request Form or fax coversheet.

4. The CC's supervisor or their designee at the agency/care system/county will review the BEI request to ensure service or item meets criteria for BEI ensuring it is not a covered benefit, additional documentation is included with the request, rationale section documentation supports the request for the service or item, the form is completed thoroughly and accurately, etc. The CC will indicate on the inquiry form the date the supervisor or designee reviewed the form. If this is section is marked "no" and/or no supervisor contact provided, it will be returned to the CC and not processed.

5. The CC will fax the completed BEI Form including any required supporting and additional documentation to the fax number on the BEI Form.

6. Medica will receive the request and has 14 calendar days to process the BEI.

7. It is very important that the BEI contain all the information needed for the BEI team to make a determination including rationale that is a thorough summary of the request. If additional information is needed to complete the inquiry determination, a Medica staff person may reach out to the CC via email or phone to obtain the information. The CC must submit the requested information timely to adhere to the 14-calendar day turnaround time requirement. The BEI may not be accepted and returned to CC to resubmit with the information needed. The inquiry date must be updated if resubmitted.

8. If the inquiry is **approved**, an authorization letter will be sent to the member and the provider indicating the dates of the authorization. The CC will be notified by email from the Medica Support Specialist or will receive a fax from Medica Utilization Management of the authorization letter. The CC will need to coordinate with the member and the provider and ensure the member receives the service or item.

9. If the inquiry is **denied**, the member, Primary Care Provider, and provider will receive the letter of denial which includes member appeal rights. The CC will receive the denial letter via fax. The CC will review with member and can refer member to their appeal rights if needed.

10. If an item has been approved through BEI, and the member continues to have the need past the approval timeline, it is the Care Coordinator's responsibility to submit the new/updated BEI request **prior to the end of the current authorization.**

BEI REQUEST Exclusions:
Medica will **NOT** accept BEI requests for the following reasons:

1. The requested service or item is a covered benefit.

2. The requested service or item requires a prior authorization as listed on the Medica Prior Authorization List. The request must follow the Prior Authorization process. This includes out of network provider requests.
    a. Medica will accept out of network Personal Care Assistant (PCA) requests submitted via BEI by faxing the BEI form. The CC must additionally complete #13 on the form. The BEI form will be forwarded to Utilization Management (UM) Prior Authorization Team for review and the decision. The UM team will notify the CC of the decision by fax. If the request is approved, the member and provider will receive an authorization letter. If the request is denied, the appeal rights are included in a letter to the member. The CC will need to continue to coordinate the member's PCA services.

3. Request is for pharmacy, dental, mental health, or claim denials from a previous request.

4. The requested item or service has previously been denied. Medica will not accept another BEI request for that service or item. The Care Coordinator can refer the member to their denial letter that incudes member appeal rights. The member can follow the appeal process.

5. Authorization requested by the provider for a service or item that does not require an authorization/referral.

6. Chiropractic care to exceed the benefit or request an out of network provider. Provider must contact Optum Health Physical Health.

7. The service or item was previously denied, and member completed the appeal process and decision was upheld, or member is currently in the appeal process for the same service or item.

8. Requests to exceed the Department of Human Services (DHS) residential tool/customized living tool rate. Request to exceed Environmental Accessibility Adaptations (EAA) DHS Elderly Waiver limits.

9. Medica **will not accept** BEI requests if they are incomplete. Examples are below. The CC can resubmit the BEI with the required information:
   a. All sections on the form are not fully completed. Examples include:
      i. Boxes empty, provider information missing, cost not included, incorrect Healthcare Common Procedure Coding (HCPC) or no HCPC, etc.
      ii. Duration and/or cost of service request is not indicated.
      iii. Alternative resources are not addressed
   b. Request is not checked that it has been reviewed by a supervisor and/or date is not indicated.
   c. Missing pages
   d. Eyewear requests that do not list EyeKraft as a provider and/or does not include documentation from EyeKraft.
   e. Rationale section lacks supporting information for the request.
   f. Required or additional supporting documents are not included in the BEI, examples include EW cost cap tool, Service Plan, PT/OT/ST documentation, DME description of item, physician notes, mental health, dietary consults.
      i. Note: A prescription from a physician is not sufficient documentation without supporting physician notes
   g. Request for waivered service for SNBC members when screening dates and notes are not indicated on the form.

CROSS REFERENCES:

Benefit Exception Inquiry (BEI) Form
Benefit Exception Inquiry (BEI) Form Instruction
Medica Care Coordinator Training Manual: Medica AccessAbility Solution
Medica Care Coordinator Training Manual: Medica Dual Solution/Medica Choice Care MSC+

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