

Benefit Exception Inquiry (BEI) Form Instructions

The instructions below guide you through completing a BEI request for Medica members on the following plans:

- Medica AccessAbility Solution® - for Special Needs Basic Care (SNBC)
- AccessAbility Solution Enhanced® (SNBC Integrated)
- Medica Choice CareSM MSC+ - for Minnesota Senior Care + (MSC+)
- Medica DUAL Solution® - for Minnesota Senior Health Options (MSHO)

General Instructions:

Medica allows flexibility in benefits provided for Special Needs Products. It is our policy to administer these benefits equitably. Use the Benefit Exception Inquiry (BEI) form to:

- Request a service/item outside of the standard benefit set covered by the product.
- Request to exceed Department of Human Services (DHS) case mix cap for MSHO/MSC+ Elderly Waiver (EW) members

Please fax completed form to **952-992-2589** along with all supporting documentation (ie: therapy evaluations, physician documentation, EW case mix cap tool, etc.). Note, specific supporting documents are required, depending on the request. A reply will be given in 14 calendar days via email or phone. If BEI does not include sufficient information, it will be returned to the care coordinator (CC). Please reference the BEI Request Policy for details regarding BEI policy and process.

Note: If the request is to see an out of network provider other than PCA or Home Care Nursing, the provider must follow the prior authorization process available on Medica.com.

Urgent Requests: Urgent request can be submitted when they relate to immediate health and safety concerns of the member. When submitting, please indicate “Urgent” on the request.

Section 1 Member & Care Coordinator Information:

1. **Date of member inquiry:** (Date of inquiry starts the 14 day turn-around timeline).
 - a. *This area must be completed for **all** BEI Requests*
 - b. *This is day one of 14 – must fax in ASAP*
 - c. ***If resubmitting the request, update the inquiry date***
2. **Member Name:** member’s legal first and last name
3. **Member DOB:** member date of birth in MM/DD/YY or MM/DD/YYYY format
4. **Member Medica ID#:** Medica’s 16 digit ID number to be entered
5. **Product:** indicate by checking the box next to the appropriate product
6. **If MSHO/MSC+ waiver and case mix information:** indicate waiver status. If on Elderly Waiver (EW), indicate case mix and case mix cap
7. **If AccessAbility, SNBC Waiver Status:** If member is on a waiver, check the type of waiver. If no waiver, check “NA” and complete the date the member will be or was last screened for the waiver. Use the “Notes” section to provide additional details regarding waiver status
8. **Name of care coordinator (CC):** fill in full name of CC
9. **Delegate Name:** fill in name of delegate
10. **CC phone number:** enter 10 digit phone number (include extension if applicable)
11. **CC email:** fill in full CC email address

12. **CC fax number:** enter 10 digit fax number
13. **PCA Out Of Network (OON) Requests- OON agency email address and NPI or TIN#:** *Complete this only if requesting out of network PCA not covered under the 120 day out of network continuity of care. The BEI request will be reviewed by another department at Medica. The CC will be notified 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.*
14. **BEI Reviewed with Supervisor:** Check "yes" box if the BEI was reviewed by supervisor.
15. **Supervisor's email:** Include email contact for supervisor who reviewed BEI. Note: BEI will be returned if not checked "yes" and/or a supervisor email is not included
16. **Primary Care Physician:** fill in the name of the members Primary Care Physician (PCP)
17. **Primary Care Clinic name:** Indicate PCP clinic name
18. **Primary Care Clinic address:** Indicate PCP clinic address
19. **Primary Care Clinic Fax:** Indicate PCP clinic fax

Section 2: Service information:

1. **Service/Item description/code:** Indicate the service or item being requested. Include name of item/service and the HCPC codes for any DME items, service codes.
2. **Provider name/address/phone/fax number:** Indicate the provider name who will be providing the service/item, address and include the phone and fax contact information.
3. **Units (hrs/days/week/months):** indicate the number of units for the service/item requested.
4. **Duration of service span (start date/end date):** indicate the start and end date of the requested service or item.
5. **Cost:** indicate the cost of the service/item, or if request is to exceed cap the additional cost.
6. **Primary Diagnosis related to the request (include code description):** include diagnosis code and description. Include additional diagnosis and codes as appropriate
7. **Rationale to support the need for requested item/service: Include reason for the request. Use this section to describe what the members need is and provide details of why a BEI request has been submitted. This area is used by the CC to explain the details regarding this request.** If the BEI does not include sufficient information, it will be returned to the care coordinator. Do not write, "see documentation". Use this section to provide a summary to support the need and of the documentation if included in with the BEI.
8. **Alternative resources CC has researched/attempted (be descriptive: ex. load closets, private funds, friend/family, non-profit community organizations, informal supports, etc.):** Indicate alternative resources that have been explored.
9. **If member has been receiving the service or item requested, how has this been provided?"** Indicate how member has received or is currently receiving this item/service. Examples may be private pay, group home provided, other waiver, previously approved BEI, or other sources. If this does not apply, indicate not applicable.

Section 3: Additional Documentation:

1. **Required Documents attached to support need/request (Check all that apply):** Check document/s included with the BEI. Include all supporting documents that pertain to the request. Note if the request requires additional documentation and it is not included in the request, the BEI will be returned.
 - a. *EW case mix cap tool- (required if member is on EW): include Medica cost cap tool for all members on EW, or other document indicating member's cost for services*

- b. *Current service plan- (required for all requests): include list of services/supports member is currently receiving. This may be the Service Plan section of the Collaborative Care Plan, service plan section of the SNBC Care Plan, or applicable section of CSSP or other care plan. Include only pertinent sections of the Care Plan*
- c. *Physical/Occupational/Speech Therapy notes if applicable: include for requests for DME items or other needs as appropriate*
- d. *Durable Medical Equipment (DME): – Description of item if applicable: include DME providers item description including costs, if applicable*
- e. *EyeKraft Cost Sheet (required if submitting BEI for eyewear): Include documentation obtained from EyeKraft that includes details regarding the request*
- f. *Physician's Notes- (a prescription alone cannot be submitted as documentation): include physician order for item and additional documentation for request as applicable*
- g. *Other: submit other documentation as applicable to support the request*

NOTE: *When submitting supporting documentation please refrain from sending in numerous pages of documentation not relevant to the request and/or highlight/call out the areas within the document that support the need requested. Documentation needs to be current.*

Suggested Resources:

Medica Customer Service, DME grid, DME provider, waiver worker, Minnesota Health Care Program (MHCP) manual, Community Based Service Manual (CBSM), Centers for Medicare and Medicaid Services (CMS), Medicare.gov, MnHelp.info: a list of suggested resources for the CC to reference to determine member benefits

After this request has been reviewed by the BEI team at Medica, the care coordinator will receive a communication back regarding the status of the request.

- If approved, a referral will be entered into Medica's system. The CC will receive an email or a fax of the authorization letter. The CC can proceed with coordinating services.
- If the request has not been approved, the member, PCP, provider and CC will receive a denial letter which includes member's appeal rights. The CC can refer member to their appeal rights, as needed. For the most current and up to date information and forms, please visit <https://www.medica.com/care-coordination/>